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ABSTRACT

This document, comprising the first of two parts, contains testimony examining the vulnerability of today's youth to health problems because of risky sexual behaviors and substance abuse, and how adolescents may be encouraged to make healthy choices. An opening statement by Representative Patricia Schroeder is presented. Testimony from these witnesses is included: (1) Jose Duran, executive director, HOPE, Hispanic Office of Planning and Evaluation, Inc. Boston, Massachusetts; (2) William Gardner, associate professor of psychiatry, University of Pittsburgh, Pittsburgh, Pennsylvania; (3) Lloyd J. Kolbe, Director, Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, Public Health Department, U.S. Department of Health and Human Services; (4) Rae Ellen McKee, 1991 Teacher of the Year, Pointe, West Virginia; (5) Linda Dianne Meloy, assistant professor of pediatrics, Children's Medical Center, Medical College of Virginia, Virginia Commonwealth University, Richmond, Virginia; (6) Mary Jane Rotheram-Borus, associate professor, division of child psychiatry, Columbia University, New York, New York; (7) Kathleen M. Sullivan, director, Project Respect, Golf, Illinois; (8) Dorothy Wodraska, assistant director, Project I-STAR, Inc., Indianapolis, Indiana; and (9) Lenore Zedosky, assistant director, office of educational support services, West Virginia Department of Education, Charleston, West Virginia. Prepared material from Representatives Dave Camp, Clyde Holloway, and Patricia Schroeder, as well as from other individuals, are included. (LLL)

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THE RISKY BUSINESS OF ADOLESCENCE: HOW TO HELP TEENS STAY SAFE—PART I

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HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, JUNE 17, 1991

Printed for the use of the
Select Committee on Children, Youth, and Families

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CONTENTS

	Page
Hearing held in Washington, DC, June 17, 1991	1
Statement of:	
Duran, Jose, M.C.P., executive director, H.O.P.E., Hispanic Office of Planning and Evaluation, Inc., Boston, MA	83
Gardner, William, Ph.D., M. Stat., associate professor of psychiatry, department of psychiatry, University of Pittsburgh, School of Medicine, Pittsburgh, PA	11
Kolbe, Lloyd J., Ph.D., Director, Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion. Centers for Disease Control, Public Health Department, U.S. Department of Health and Human Services, Atlanta, GA	22
McKee, Rae Ellen, 1991 National Teacher of the Year, Pointe, WV	68
Meloy, Linda Dianne, M.D., FAAP, assistant professor of pediatrics, department of pediatrics, division of general pediatrics, Children's Medical Center,Medical College of Virginia, Virginia Commonwealth University, Richmond, VA	44
Rotheram-Borus, Mary Jane, Ph.D., associate professor, division of child psychiatry, Columbia University, New York, NY	34
Sullivan, Kathleen M., director, Project Respect, Golf, IL	99
Wodraska, Dorothy, assistant director, Project I-STAR, Inc., Indianapolis, IN	70
Zedosky, Lenore, assistant director, office of educational support services, West Virginia Department of Education, Charleston, WV	61
Prepared statements, letters, supplemental materials, et cetera:	
Ambach, Gordon M., executive director, Council of Chief State School Officers (CCSSO), Washington, DC, prepared statement of	137
Camp, Hon. Dave, a Representative in Congress from the State of Michigan, prepared statement of	135
Caperton, Gaston, Governor, State of West Virginia:	
Building a Healthy Future, West Virginia Task Force on School Health (a report)	172
Letter to Hon. Patricia Schroeder, chairwoman, Select Committee on Children, Youth, and Families, dated June 12, 1991	170
Dryfoos, Joy G., Hastings-on-Hudson, NY, independent researcher and author, prepared statement of	200
Duran, Jose, M.C.P., executive director, H.O.P.E., Hispanic Office of Planning and Evaluation, Inc., Boston, MA, prepared statement of	89
Gardner, William, Ph.D., department of psychiatry, University of Pittsburgh, School of Medicine, Pittsburgh, PA, prepared statement of	14
Holloway, Hon. Clyde, a Representative in Congress from the State of Louisiana, prepared statement of	136
Kolbe, Lloyd J., Ph.D., director, Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA:	
Prepared statement of	24
Response from Lloyd Kolbe, Ph.D., to questions posed by Congressman Frank Wolf	212
Levy, Janet E., director, Joining Forces, Washington, DC, prepared statement of	139
Lipsitt, Lewis P., Ph.D., executive director for science, The American Psychological Association, Washington, DC, prepared statement of	187
McKee, Rae Ellen, 1991 National Teacher of the Year, Pointe, WV, prepared statement of	69

Page

Prepared statements, letters, supplemental materials, et cetera—Continued
Meloy, Linda Dianne, M.D., FAAP, assistant professor of pediatrics, department of pediatrics, division of general pediatrics, Children's Medical Center, Medical College of Virginia, Virginia Commonwealth University, Richmond, VA, prepared statement of 47
Rotheram-Borus, Mary Jane, Ph.D., principal investigator of the adolescent prevention studies unit, HIV center for clinical and behavioral studies and associate professor of clinical psychology, division of child psychiatry, Columbia University at the New York State Psychiatric Institute, New York, NY, prepared statement of 38
Schroedor, Hon. Patricia, a Representative in Congress from the State of Colorado and chairwoman, Select Committee on Children, Youth, and Families:
Letter to Kathleen M. Sullivan, director, Project Respect, dated June 27, 1991, requesting information posed by Congressman Frank R. Wolf 219
Letter to Lloyd Kolbe, Ph.D., dated June 27, 1991, requesting information for the record 210
Opening statement of 2
"The Risky Business of Adolescence: How To Help Teens Stay Safe" (a fact sheet) 4
Sullivan, Kathleen M., director, Project Respect, Golf, IL:
Evaluation Report, Illinois schools, entitled: "Sex Respect, from Project Respect 230
Final Report, Office of Adolescent Pregnancy Programs 221
Letter to Hon. Frank R. Wolf, dated June 27, 1991, submitting representative letters from teens 185
Prepared statement of 104
Vincent Murray L., Ed.D., professor, School of Public Health, University of South Carolina, Bamberg, SC, prepared statement of 196
Wodraska, Dorothy, assistant director, Project I-STAR Inc., Indianapolis, IN, prepared statement of 73
Zedosky, Lenore, assistant director, Office of Educational Support Services, West Virginia Department of Education, Charleston, WV:
Answer to question posed by Congressman Frank Wolf 199
Prepared statement of 65

THE RISKY BUSINESS OF ADOLESCENCE: HOW TO HELP TEENS STAY SAFE—Part I

MONDAY, JUNE 17, 1991

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The select committee met, pursuant to call, at 9:30 a.m., in room 2212, Rayburn House Office Building, Hon. Patricia Schroeder (chairwoman of the select committee) presiding.

Members present: Representatives Schroeder, Johnson, Riggs, Wolf, and Camp.

Staff present: Karabelle Pizzigati, staff director; Jill Kagan, deputy staff director; Madlyn Morreale, research associate; May Kennedy, professional staff; Danielle Madison, minority staff director; Carol M. Statuto, minority deputy staff director; and Joan Godley, committee clerk.

Chairwoman SCHROEDER. I think we will go ahead and call it to order.

We may have some trouble getting other Members here as we don't have votes today, so it is a little harder to corral them.

I think the temperature also may be keeping people away; stay away from the city as long as possible when it is this warm.

But I do really want to welcome everyone to this, which is the beginning of a two-part hearing on the risky business of being an adolescent and how to keep teens safe.

I think adolescents always have faced threats, but this generation seems to be facing the threat that has not been confronted by previous generations.

It is now not only risky to be a teen, it can be very deadly. If we look at the statistics, sexual activity rates are still climbing; and adolescents are the least apt to use contraceptives.

The number of AIDS cases among young adults suggests alarming rates of HIV-infected teenagers. The rates of chlamydia and gonorrhea are higher for teenagers than any other age group in our population.

And drug and alcohol abuse remain rampant, despite a well funded national program to try and stem the tide.

In this series of hearings that we are beginning today, we are going to hear about ways to help young people make healthy choices, to engage parents and other adults in that process, and some exciting efforts to make an adolescent's world more health promoting.

Part of our failure to help teens stay safe is our stereotypical view of which youth are at risk. We cannot make sure that young people remain safe because they fall outside of the groups that we think are high risk, because not all disadvantaged teenagers are troubled and not all troubled teens are disadvantaged.

For example, suburban athletes who may be injecting steroids could be very much at risk of HIV infection. We now see that black young children have lower rates of substance abuse than white children.

We see that the teen pregnancy rates have stabilized in minority youth but are still climbing among white adolescents, so a lot of our stereotypes fall apart when we look at the numbers.

We know that skills and self-esteem help a teen resist peer pressure to abuse drugs and are just as badly needed when a child receives pressure to have sex. Unfortunately, we do not allow our drug abuse prevention classes to talk about sex, and we should be really looking at the whole area.

When we get to sex and other such issues, we find that families are afraid to bring the subject up, that family communication is terribly critical, and yet some of the people who protest the loudest about wanting families to carry on this communication, when pressed, will also admit they feel that they are totally incapable of dealing with it.

One study was very telling. It found that teenaged girls who knew what kind of contraceptives their mothers used were not more likely to be sexually active than other girls, but if they were sexually active, were much more apt to use contraceptives.

So it is very interesting to notice that what some people fear there is no evidence to substantiate.

We have not found any evidence that explicit information about how to lower the risk makes teens more apt to take the risk. So that, I think, is basically good news.

We are very concerned about gag rules wherever they appear. It appears we don't need a Supreme Court to put a gag rule on a family. The tradition or fear of confrontation or not feeling knowledgeable or not wanting to discuss personal things often gag a family almost automatically.

We did get the Supreme Court, I guess, gagging doctors. But either way, the result is the same. Teens aren't getting the full range of information that they need.

Today we are going to learn about the risks they run and the best ways to reach them with vital information, whether it is through schools or community-based organizations.

[Opening statement of Hon. Patricia Schroeder follows:]

OPENING STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO AND CHAIRWOMAN SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Today's adolescents face threats unlike those confronted by previous generations. Experimentation with adult behaviors has always characterized adolescence. It has always been risky. Now it can be more deadly than ever before.

Sexual activity rates of the youngest adolescents are still climbing, and young adolescents are the least likely to use contraception.

The number of AIDS cases in young adults suggests alarming rates of HIV infection in teenagers.

The rates of chlamydia and gonorrhea are higher for teenagers than for any other age group.

Drug and alcohol abuse remain rampant despite a well funded national campaign to stem the tide.

In the series of hearings that begins today, we will hear about ways to help young people make healthy choices, engage parents and other adults in the process, and about exciting efforts to make adolescents' worlds more health-promoting. Part of our failure to help our teens stay safe is our stereotypical view of youth at risk. We cannot rest assured that young people remain safe because they fall outside of groups which have been labeled "high risk."

Not all disadvantaged teens are troubled, and not all troubled teens are disadvantaged. For example, the suburban athlete who shares a needle while injecting steroids is at high risk of becoming infected with HIV, despite the apparently idyllic nature of his world. Also contrary to common perceptions, studies show that black children have lower rates of substance abuse than white children, and that while sexual activity and teen pregnancy rates have stablized in minority youth, they are climbing among white adolescents.

Our witnesses will explain that it is not who teens are, but what they do, and the environments of the schools they go to and the communities they live in that help them stay safe. But we face a major roadblock in the path of preventing problems in adolescents—our narrow, categorical view of the risks they run.

Young people increasingly know that the same risky behaviors put them at risk of pregnancy, sexually transmitted diseases, and drug addition. We cannot afford to lose credibility with them by putting some of this behavior on the list of forbidden topics.

The skills and self-esteem that help a teen resist peer pressure to abuse drugs are just as badly needed when the child receives pressure to have sex. But we do not allow our drug abuse prevention classes to "stray" to examples dealing with sexual negotiations.

Families are afraid to bring up the subject because they are embarrassed, they don't feel knowledgeable, they fear a confrontation, or simply because they don't know what language to use to talk about very personal matters.

This is sad, because family communication is so critical. One telling study found that teenaged girls who know what kind of contraception their mothers use are not more likely to be sexually active than other girls, but are more likely to use contraception if they are sexually active.

There is no evidence that explicit information about how to lower risk makes teens more likely to *take* risks. Instead of bogging down in endless speculation about this, we should be teaching teens the skills they need to follow their own convictions—convictions that often turn out to be surprisingly similar to their parents'.

Gag rules, whether in a doctor's office or in a family, only jeopardize the health status of adolescents.

Today we will learn about the risks adolescents run, and the best ways to reach them with vital information through schools or community-based organizations.

We welcome all our witnesses, and are especially pleased to welcome Rae McKee, the 1991 National Teacher of the Year, who is accompanying our witness from West Virginia. I'm eager to hear about your valuable frontline experience.

Thank you all for coming.

THE RISKY BUSINESS OF ADOLESCENCE: HOW TO HELP TEENS STAY SAFE

FACT SHEET

DRUGS, PREGNANCY, HIV, AND OTHER STDs THREATEN HEALTH OF MILLIONS OF YOUTH

- Eight million junior and senior high school students (nearly 40% of this population) report weekly consumption of alcohol, including 5.4 million students who have "binged" with five or more drinks in a row, and 454,000 who report an average weekly consumption of 15 drinks. (U.S. Department of Health and Human Services [DHHS], 1991)

- In 1989, 91% of graduating high school seniors reported having consumed alcohol, 44% had used marijuana, 19% had used stimulants, 18% had used inhalants, 10% had used cocaine, and 9% reported having used hallucinogens. (National Institute of Drug Abuse, 1990)

- Approximately 1.1 million teenage girls become pregnant every year. In 1988, nearly 489,000 babies were born to girls under age 20 and the birth rate for girls ages 15-17 was at its highest level since 1977 with 33.8 births per 1,000 population. (DHHS, 1990; National Center for Health Statistics, 1990)

- Of AIDS cases reported in the U.S. by April 30, 1991, one in five was among young adults in their twenties. The average latency period between HIV infection and AIDS diagnosis is eight to ten years, therefore, many young adults probably were infected as adolescents. The total number of AIDS cases reported among persons ages 13-24 increased by 75% between 1989 and 1990. (Centers for Disease Control [CDC], 1991)

- Three million teens are infected with a sexually transmitted disease (STD) annually. Nearly two-thirds (63%) of all STD cases occur among persons under 25 years of age. Adolescents have higher rates of gonorrhea and chlamydia than any other age group. Left untreated, these diseases may lead to pelvic inflammatory disease which can cause infertility or fetal loss. (CDC, 1991; American Social Health Association, 1991)

SEXUAL ACTIVITY INCREASES AMONG TEENS; MANY ARE UNPROTECTED AGAINST PREGNANCY AND STDs

- An estimated 78% of adolescent girls and 86% of adolescent boys have engaged in sexual intercourse by age 20. Among girls ages 15-19, 53% were sexually active in 1988, compared with 47% in 1982. Much of this rise is associated with increased sexual activity among white and non-poor females. Among boys under age 19, the percent who were sexually active increased from 78% in 1979 to 88% in 1988. (DHHS, 1990; Darroch Forrest and Singh, 1990; Sonenstein, et al., 1989)

- The percent of U.S. teen girls practicing contraception rose between 1982 and 1988 from 24% to 32%. Nevertheless, in 1988, more than one-third (35%) of girls ages 15-19 reported no method of contraception at first intercourse and 82% of pregnancies among teenage girls were unintended, compared with 78% in 1982. Among never-married males living in metropolitan areas, 58% reported condom use at last intercourse in 1988. (Moser, 1990; Darroch Forrest and Singh, 1990; Sonenstein, et al., 1989)

- A study of 222 African-American teenage crack users found that 96% were sexually active, 62% had sold crack, 51% had combined crack use and sex, 41% reported a history of STDs, and 25% had exchanged sexual favors for drugs or money. While the average age of first intercourse was 12.8 years among the study population, the age at first condom use was 14.8 years. (Fullilove, et al., 1989)

COSTS OF DRUGS, STDs, PREGNANCY, AND HIV ARE STAGGERING

- Between 1985 and 1989, approximately 40,600 youth ages 15-24 died in alcohol-related motor vehicle accidents. (CDC, 1991)

- The aggregate annual costs of herpes, gonorrhea, chlamydia, and pelvic inflammatory disease are estimated to total $8.4 billion. (CDC, 1991)

- In 1988, families started by teen parents cost an estimated $19.83 billion in AFDC (Aid to Families with Dependent Children) payments, Medicaid, and food stamp outlays. If every birth to a teen mother had been delayed, an estimated $7.93 billion would have been saved. Federal funding for family planning services decreased by 39% between 1981 and 1991, adjusting for inflation. (Center for Population Options [CPO], 1990)

- The estimated health care expenditures for a typical AIDS patient from diagnosis to death range from $55,000 to $80,000. By 1992, the projected annual costs of AIDS are as high as $13 billion, not including treatment with expanded use of specific antiviral drugs, such as zidovudine (AZT) for asymptomatic HIV infected people. (Congressional Research Service, 1990; DHHS, 1990)

FORMIDABLE BARRIERS TO PREVENTING HIGH-RISK BEHAVIOR AMONG YOUTH REMAIN

- Approximately 4.6 million adolescents lack public or private health insurance, including nearly one-third of all poor adolescents. Of the estimated 21.7 million adolescents who are covered by private health insurance, one-third are not covered for maternity-related services by their parents' insurance. (Office of Technology Assessment, 1991)

- Fewer than half (47%) of sexually active teens surveyed reported having talked with their parents about sex and birth control. Nearly six in ten (58%) of sexually active teens who have discussed both of these issues with their parents report consistent use of birth control, compared with 16% of sexually active teens who have talked with their parents about sex but not contraception. (CPO, 1990)

- A 1989 survey of over 4,000 public school teachers who provide sex education found that while 75% believed that a wide range of topics related to the prevention of pregnancy and infection should be taught before the end of the seventh grade, only 35% reported that sex education was provided in grades seven and eight. Virtually all teachers (97%) felt that sex education classes should include information about how students can obtain birth control, but only 48% were in schools where this was done. (Darroch Forrest and Silverman, 1989)

- During the 1988-89 school year, two-thirds of school districts nationwide required that HIV education be provided at some time for students in grades 7-12. Only 15% of school districts provided HIV education in grades 11-12, although rates of sexual activity are known to increase markedly during this period. One-fifth of HIV teachers reported having received no specialized training in the subject. (Government Accounting Office, 1990)

COMPREHENSIVE, INTEGRATED SKILL-BASED PREVENTION PROGRAMS SHOW RESULTS

- A recent analysis of 100 programs that were successful in reducing high-risk behaviors among youth found several common strategies: Intense one-on-one individual attention; social skills training; involvement of parents, peer educators, and schools; preparation for entering the labor force; and community-wide, multi-agency approaches to provide resources and reinforce messages. (Dryfoos, 1990)

- Participants in a comprehensive drug abuse prevention program for students in grades 6-7 were at least 50% less likely than students in a control group to use cigarettes, alcohol, or marijuana one year after the study. Parents of participating students were more likely to report reduced alcohol use and increased physical activity. The program supplemented peer pressure resistance skills training with parental involvement, community organization training, and promotion of local health policy change. (Pentz, et al., 1989)

- An integrated rural school and community-based family planning program in South Carolina targeting adolescents, parents, and teachers in graduate training yielded a 56% reduction in the estimated adolescent pregnancy rate. (Vincent, et al., 1989)

- Initial data from a study of 144 gay and bisexual youth indicated that 83% did not know that HIV can be transmitted during oral sex, 75% engaged in unprotected rectal intercourse and/or needle sharing, and 18% were chemically dependent. After participating for three months in a model prevention program which included an initial assessment, individual risk reduction counseling, peer education, and referral to psychosocial services, self-reported consistent condom use rose sharply (from 44% to 73%) and participants were significantly less likely to report oral sex and symptoms of dysfunctional substance abuse. (Remafedi, 1990)

June 17-18, 1991

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Tips for Parents about How to Talk to Children About Sex

1. Parents are the primary sexuality educators of their children, and should begin to talk with them about this natural part of life when they are very young. Children want to discuss these issues with their

parents and want to hear their values. Do some thinking ahead so you know what you want to say about your feelings and attitudes. Your children look to you as a model, and your values provide them with valuable guidelines for making choices.[a]

2. The most important step you can take is to say the first words. Children do not always ask questions about sexuality, so you must begin.[a]

3. Try to answer your children's questions as they come up. It is never a good idea to tell children that they need to wait until they are older before you will answer their questions.[a]

4. Let your children know that they can always ask you any questions they may have.[a]

5. Teens need to know that sex will never hold a troubled relationship together. Fear of being alone is not a good reason to have sex.[b]

6. Let them know that decisions about sex should not be based on what others do, but on one's own feelings. Sex won't make anyone popular or feel better about himself or herself.[b]

7. Don't make the assumption that sex is your teen's major concern, or that sexual thoughts are only about intercourse. Tell your kids that thinking about sex is normal and that you know thinking about something is not the same as doing it.[b]

8. Adolescents crave privacy, but that doesn't mean they don't want you to be involved in their lives. Show that you are interested without demanding intimate details. Teens need to know you trust them.[b]

9. It's important for you to be honest. If you don't think your teenager is ready for a sexual relationship, say so and explain why. Teens need more than "just say no."[b]

10. Tell it like it is. Avoid fables, vague explanations, and untruths when talking about conception or birth.[c]

11. Give simple explanations. Use appropriate names for parts and functions of the body. Children need a language to use when talking about their feelings, ideas and concerns.[c]

12. Get to know your child's environment. Current jokes, the TV and news programs they're watching, their music -- these will provide unlimited opportunities to discuss sexuality issues.[c]

13. Separate the child from the behavior. If your child does something inappropriate, label the behavior inappropriate, not the child bad.[c]

14. Sexuality education doesn't mean teaching kids how to have sex -- sexuality is about body image, gender roles, feelings about oneself that carry into adult relationships, as well as reproduction.[c]

15. Build up your children's self-esteem. Recognize their talents, personalities and accomplishments, and avoid comparing them with others. Reassure your youngsters -- especially when they're going through puberty -- that they are normal. A strong sense of self-worth helps determine the kind of choices they will make, sexual choices as well as other important life choices. Children who feel good about themselves are less susceptible to peer pressure and better equipped to make responsible decisions.[d]

16. Don't be afraid of not being an expert. If you don't know the answer, admit it, and then find out. Or you and your child can find the answer together by sitting down with a book.[d]

17. Educate yourself about HIV/AIDS and other sexually transmitted diseases, and make sure your children have the information they need to protect themselves. For example, they should know that latex condoms with nonoxyl-9 spermicide are much more effective than other types of condoms.[a]

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[a] How to Talk to Your Children About AIDS, (1989) Sex Information and Education Council of the U.S. (SIECUS), New York, University, New York, New York.

[b] Talking With Your Teenager About Sexual Responsibility, (1989) ETR Associates, Santa Cruz, California.

[c] A Guide for Parents and Kids, Talking Together About Sexuality, Governor's Council on Adolescent Pregnancy, Baltimore, Maryland.

[d] How to Talk To Your Child About Sexuality, (1990) Planned Parenthood, New York, New York.

Chairwoman SCHROEDER. We want to welcome all of our witnesses and are especially pleased to welcome Rae Ellen McKee, the 1991 National Teacher of the Year, who will be accompanying our witness from West Virginia.

We are very, very eager to hear about the valuable front line experience and thank all of you for coming.

I would like to yield to my distinguished colleague. Did you have anything you would like to add in an opening statement?

Mr. JOHNSON. No, I don't, Madam Chairman, other than to say I want to commend you for holding this very timely hearing on a critical issue.

I am looking forward to the testimony today on the risky business of adolescence, how to help teens stay safe.

We are going to have some very interesting testimony today really to the types and extent of risks run by teens, what has worked best in school-based programs, and some success stories with high-risk youth.

I think that as we analyze what sort of Federal response we can make to this tremendous challenge that we face today, this hearing will make a very constructive contribution.

I am looking forward to listening to the panelists and thank you again for convening this hearing.

Chairwoman SCHROEDER. Thank you.

And let me call our first panel to the table. First we have William Gardner, Associate Professor of Psychiatry at the University of Pittsburg School of Medicine.

We have Dr. Lloyd Kolbe, who is the Director of the Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control in Atlanta, Georgia.

And we have Dr. Mary Jane Rotheram-Borus—I hope I got that right, Mary Jane—who is an Associate Professor of the Division of Child Psychiatry, Columbia University, New York, New York; and Linda Dianne Meloy, who is a doctor and an Assistant Professor of Pediatrics at the Division of General Pediatrics, Children's Medical Center, Medical College of Virginia, Virginia Commonwealth University in Richmond.

So I want to welcome this very distinguished panel and say how delighted we are to have you try and help us figure out how we handle adolescents.

I don't think there is an adult alive who, given the option, would go back and go through adolescence again. I know very few people who found it a positive experience, and I know one popular writer says in every high school in America there are only two happy people, the captain of the football team and the young woman he is dating.

I hope it is not quite that troubled and that awful, but I think everybody has had those kind of experiences. So we are very happy to have our panel here today to give us some guidance.

And let's start with you, Dr. Gardner, if that is all right. The floor is yours.

STATEMENT OF WILLIAM GARDNER, PH.D., M. STAT., ASSOCIATE PROFESSOR OF PSYCHIATRY, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF PITTSBURGH, SCHOOL OF MEDICINE, PITTSBURGH, PA

Mr. GARDNER. Thank you very much.

Actually, I thought it was the high school valedictorian and the young man she was dating, but I could be wrong.

Chairwoman SCHROEDER. That could be.

Mr. GARDNER. Madam Chairwoman, I have looked at the list of witnesses, and it is clear to me that you will get a lot of good information about programs that can help prevent risk-taking behavior among adolescents. What I will do, however, is serve as the bearer of bad news. I am, frankly, very alarmed about this problem. And I have become more alarmed just in the process of preparing this testimony.

Let me make three points. The first concerns the size of the problem of AIDS among adolescents. I think it is a very large problem. It is not peripheral to the epidemic. It is not a hypothetical problem.

Second, I would like to give a report on the overall effect of our prevention efforts to date. The report is that we are failing to prevent the risk-taking behaviors that spread AIDS and HIV infection among adolescents.

And then, finally, I will give a brief overview of some of the things I think are reasons or causes for that failure, and perhaps introduce the rest of the speakers by identifying some ways to do a better job.

First, how big is the problem? Well, as you know, the process of the disease of AIDS is long and complex. It begins with HIV infection, and then there is a long period—perhaps seven years, perhaps 12 or 13 years—when the disease remains latent. Then eventually, we have the syndrome of diseases called AIDS. So if we want to understand patterns of risk of HIV infection among adolescents, we have to look at people who are diagnosed with AIDS in their early 20s and in their later 20s.

This is a large group of people. It is over 20 percent of the total cases. If, as the CDC estimates, there are a million people in America who are currently HIV positive, I would guess that one in 10 may have acquired their infection during adolescence.

Now, how do these kids get infected? The data show clearly that they get infected in the same ways that adults do. That is, primarily through sexual contact and through IV drug use. It is important to escape from our stereotypes about kids and to recognize that they are taking serious risks, that we cannot pretend that it isn't happening, and that we need to give them the information they need to protect themselves.

Now, why do I think that efforts to prevent HIV infection are failing? When I prepared a book on this topic a year ago, I expected that by this time we would have some positive news to report. There are several encouraging studies that have been reported from the gay male cohorts in San Francisco, that showed that these groups of men have reduced the numbers of high-risk behaviors they engage in. I thought that given the publicity about AIDS

over the last decade, we would see something similar among adolescents. And I am very sorry to say that as far as I can tell, the opposite is true.

I was shocked to learn from data published by the CDC that from 1985 to 1988, the age of first intercourse for American girls actually declined. To give you a sense of this, in 1985, 42 percent of girls age 17 had had intercourse. I think that is a large number. It is a disturbing number, given the rate of sexually transmitted diseases and the very high risk of becoming infected with a sexually transmitted disease at that age. But in 1988, it was 51 percent, and this is in the light of all the information about AIDS that is available to people at this point.

I was also upset by conversations with several noted researchers in San Francisco who are studying gay male adolescents. These young men are not learning the lessons that have been learned by older gay men. The whole experience that produced the great change in sexual norms in the older generation of gay men does not seem to have affected young gay adolescents. These kids are engaging in high-risk behaviors like unprotected anal intercourse and finding their sexual partners in settings where there is a substantial prevalence of HIV infection. This tells me, and it tells these other scientists, that the AIDS epidemic may still be spreading rapidly in this group.

Now, why are we failing? I think there are several issues. It is hard to change risk taking behaviors in adolescents. I know this personally. Madam Chairwoman, as a Coloradan you will know many young people who are rock climbers and back country skiers. There is a real hunger for risk taking at this age. To counter that, you have to work very, very hard to accomplish prevention, and I don't think we have been doing the kinds of serious preventive efforts that are required.

Most of the efforts that I am aware of in schools and in states focus on providing information. But it is quite clear that simply providing information alone is not sufficient to change behavior.

Ninety-five percent of the kids in this country know that AIDS is lethal and that you can get it through unprotected sex. But there are many other messages around that say these risks don't apply to them. They apply to somebody else. And this rationalizes a lot of risk-taking behavior. Moreover, the adolescents who are at greatest risk—gay adolescents; runaway adolescents, who may be involved in drug trafficking and prostitution; and impoverished, delinquent youths—these kids are stigmatized, alienated and difficult to reach through the traditional public health interventions.

We know that it often takes individual attention, someone actually talking to a kid, helping them see how their particular beliefs are supporting this dangerous activity. If kids are hiding from the world, if kids don't feel they can talk about who they are and what they are doing, then it is impossible to reach these kids to help them change.

What do I think should be done? I think it is important that the Federal Government should continue to provide and expand their provision of funding for demonstration projects on how to prevent risk-taking behavior. It is essential that these preventive interventions begin early in childrens' lives and continue throughout their

schooling. I think the interventions need to embrace all risk-taking behaviors because the literature shows that risk-taking behaviors involving automobiles, involving substance abuse, involving sex, involving alcohol, all these things tend to come in a package. There is a cultural package of risk taking and delinquency that comes together. We need a preventive program that is values-based, that from the beginning teaches kids the importance of caring for themselves and watching prudently after their own health.

But they need skills. They need skills in how to protect themselves, and they need skills in how to deal with a peer culture that encourages risk-taking behavior, and they also need skills, frankly, in how to avoid being exploited and manipulated by adults who look to them for sexual satisfaction.

I also think we need support for innovative methods to deliver prevention services to high-risk kids. It is difficult to get to these kids through schools. A lot of them aren't there.

And finally, I think these programs need to be rigorously evaluated. If something doesn't work, we need to know right away. It sets back the cause immensely to have everyone get excited about the battle being won, and then discover the next time someone tries to do a study, gee, it didn't seem to work. And the reason may be that you didn't really ask yourself the tough questions about is this working, is our confidence in this intervention scientifically justified?

I also believe that the Federal Government should support expanded research on understanding the behavioral development of adolescents, and I speak as someone who is primarily a researcher in this area. Specifically, there is not much information about their sexual behavior, and that is critical to have.

If you can imagine, we are still working in many cases with data sets that are 20, 30, or 40 years old, because it has been impossible to do the large scale survey research on sexual behavior that needs to be done. Imagine if astronomers were limited to the data that were collected 40 years ago.

Chairwoman SCHROEDER. Why is it impossible?

Mr. GARDNER. Well, it is impossible because what we really need is a study that is representative of the population and that has a large enough sample that we can make confident inferences from it. It is a very big project to do one of these things. It needs to be supported by the Federal Government. Private foundations cannot put together the resources and, frankly, I don't think they can provide adequate scientific supervision to make sure the job is done well.

The expertise about how to do this is here in the Centers for Disease Control, in the NICHD, in various agencies like this. I think it is just an illusion to suppose that the Carnegie Foundation or another private foundation can put it together and do it, with no disrespect to them.

And thank you. That is my view of things.

[Prepared statement of William Gardner follows:]

PREPARED STATEMENT OF WILLIAM GARDNER, PH.D.,[1] DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE, PITTSBURGH, PA

Summary

There is a major epidemic of HIV infection among American adolescents, with several thousand youths becoming infected each year. *At present, efforts to reduce risky behaviors among adolescents are failing:* both heterosexual and homosexual adolescents continue to practice risky sexual behaviors. The primary cause of this failure is the use of one-shot, educational efforts, where intensive, long-term programs are required. The adolescents at greatest risk – gay adolescents, runaways, and underclass, delinquent youths – are stigmatized, alienated, and difficult to reach through traditional school or public health interventions. There must be expanded funding for innovative, research-based, programs to deliver prevention services to these groups.

Epidemiology of AIDS among adolescents

Acquired immunodeficiency syndrome (AIDS) is a group of diseases that indicate severe immunosuppression related to infection with the human immunodeficiency virus (HIV). The symptomatic diseases of AIDS do not appear for a long time following infection with HIV: some studies suggest that the median time from infection to full-blown AIDS may be 10 years. Thus persons who are diagnosed with AIDS in their teens will generally have acquired the infection in their early teens or as pre-teens. Similarly, many of those diagnosed with AIDS in their early and middle 20s will have become infected as teenagers. The distinction is important because the patterns of AIDS among teenagers and young adults are different.

AIDS among adolescents

As of April 1991 there were 676 persons who were diagnosed with AIDS, which is less than .5% of the total of cases. It is unclear that the health needs of this group are being

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adequately met. Dr. Gary Remafedi of the Adolescent Health Program of the University of Minnesota reports that many diagnosed AIDS cases among adolescents become lost to follow up, meaning that it is uncertain whether they are receiving medical services. It is easy to imagine reasons why some adolescents with AIDS would not be receiving adequate medical care. Fifty-six percent of persons diagnosed as teenagers reported exposure to HIV through sexual contact or IV drug use, meaning that these events must have occurred at a young age. This in turn suggests that many of these children were either sexually abused by an adult, or belonged to a family where little effective supervision occurred, or perhaps had run away from their families altogether. These teenagers would also lack a network of family or friends who can help them get medical treatment. In summary, although the number of adolescents with AIDS is comparatively small, we know little about them and there is reason to fear that their situations are grim.

Patterns of HIV infection among adolescents

Our knowledge of HIV infection among adolescents is highly uncertain, because we must draw inferences from patterns of AIDS cases diagnosed when patients have become older. It is clear, however, that many people are getting infected with HIV during their adolescence: 7,178 persons (more than 4% of all AIDS cases) have been diagnosed between the ages of 20-24 years and 27,702 persons (almost 16%) were diagnosed between 25 and 29 years old. Let me suggest that at least 1 in 10 Americans with AIDS may have acquired the infection in their teens and early 20s. The Centers for Disease Control (CDC) estimate that more than a million Americans are presently infected with HIV, so we must suppose that many tens of thousands of those persons acquired their infections during their adolescence or young adulthood. Even though the rate of new HIV infections has slowed, it is estimated that at least 40,000 new infections occur each year. Clearly we cannot say exactly how many adolescents are becoming infected with HIV each year, but it must be several thousands. The point, then, is that HIV infection among adolescents is not peripheral to the main epidemic, it is a principal component of the AIDS problem.

How are adolescents becoming infected? As it turns out, they get infected in same ways that adults do. The modes of exposure to HIV reported by persons diagnosed between ages 20-24 (most of whom would have been infected in their teens) are similar to the modes of exposure reported by those diagnosed at later ages (see Table 1). Among persons diagnosed with AIDS from ages 20 to 24, 92% reported exposure through sexual contact or IV drug usage, as compared to 93% among those who were diagnosed at age 25 or older. This is in sharp contrast to the pattern among those diagnosed as teenagers, among whom 38% were exposed through transfusion or from blood products received for hemophilia. In summary, the data suggest that persons in their late teens are exposed to HIV infection because they engage in 'adult' risk-taking behaviors.

Which adolescents are at risk of HIV infection?

Because many adolescents engage in intercourse without using condoms, they are at risk

Mode of Exposure	Age in Years		
	13-19	20-24	> 24
Heterosexual contact	13.6	10.0	5.3
Homosexual contact	26.3	56.1	59.4
IV drugs	11.5	16.6	22.3
Homosexual contact & IV	4.3	9.0	6.5
Hemophilia	30.2	2.6	0.7
Transfusion	7.4	1.5	2.3
Unknown	6.7	4.3	3.6
Total	100.0%	100.0%	100.0%

Table 1: Modes of exposure to HIV reported by persons in their early 20s and older: cumulative percentages.

for infection with HIV. There are, however, two subgroups of sexually active adolescents at particularly high risk, and that must be the focus of special attention. First, we need to prevent HIV infection among adolescents who engage in multiple risky behaviors, including runaway youths and risk-taking youths living in areas of concentrated urban poverty. Second, we need to prevent HIV infection among gay adolescents.

Adolescents at risk from unprotected sexual activity

Precocious sexual activity entails many risks for adolescents, including pregnancy and infection with sexually transmitted diseases (STDs), including AIDS. It is disturbing, therefore, to discover that despite intensive efforts to prevent teenage pregnancy and despite widespread publicity about the risks of AIDS, from 1985-1988 the age of first intercourse among American women *decreased* (see Table 2). The concern, however, is not just that

Age	Year	
	1985	1988
15	20.0	25.6
16	30.4	31.8
17	41.7	51.0
18	53.2	69.5
19	70.7	75.3

Table 2: Change from 1985 to 1988 in percentage of girls who have experienced intercourse by age.

many young adolescents are sexually active, but also about how they are having intercourse. Surveys consistently show that a majority of sexually active adolescents either never use condoms or use them inconsistently. Contrary to stereotyped beliefs about sexual behavior, many young women have experienced anal intercourse (for example, 19% of women

in a large sample from Canadian community colleges). Adolescents frequently do not use condoms when engaging in this risky behavior.

These increases in the rates of sexual activity are bad news for those who seek to prevent sexually transmitted diseases, because the groups with the highest rates of most non-AIDS STDs are sexually active adolescents. High rates of sexual activity among adolescents are likely to accelerate the spread not just of HIV infection, but may also accelerate the spread of the other STDs. The non-AIDS STD epidemics, in turn, are bad news for those working to prevent HIV infection, for two reasons. First, the genital lesions caused by many STDs open a pathway into the body whereby HIV infection can be easily transmitted during intercourse. A person with a non-HIV STD should view him or herself as at extreme risk of infection. It is unlikely, however, that many adolescents understand this, or even that all adolescents with an STD know that they are infected. Second, the high rates of gonorrhea, herpes, and other infections among adolescents demonstrate that sexually active adolescents are frequently exposed to individuals with these infections. Therefore, as HIV infection continues to spread among the adult population, and particularly among adults with other STDs, sexually active adolescents will be exposed to HIV with increasing frequency.

Risk-taking youths

Although every adolescent practicing unprotected intercourse is at risk of acquiring HIV or another sexually transmitted infection, there are some youths at far greater risk than others. Only a small percentage of adolescents use intravenous drugs, but this practice greatly increases the chance of acquiring HIV. Other adolescents have sex with multiple partners, frequently while using alcohol or other drugs, and in social contexts such as prostitution or drug distribution which place them at high risk of encountering a person with an HIV infection or other STD. Adolescents may become exposed to these risks because they are runaways, because they are part of a delinquent subculture, or because they live in an area of concentrated poverty where many behavioral and medical problems are epidemic among adults as well as youths. These are, clearly, overlapping populations.

Homeless and runaway youth. About one million adolescents run away from home each year, and many of these do not return. Both male and female adolescents on the street are likely to become involved in drug use, drug trafficking, and prostitution. Some of these youths leave home to flee abuse from parents, some are gay, others are drawn by the delinquent culture of the street. Studies of samples of runaway youths contacted through public health clinics indicate that they engage in high rates of risky behavior.

Youth in areas of concentrated urban poverty. HIV infection is increasingly prevalent in areas of concentrated poverty within the central cities, particularly among minority groups suffering from coincident epidemics of IV drug use and other STDs. Table 3 shows that blacks and Hispanics constitute a larger proportion of AIDS cases among teenagers and young persons than among older persons with AIDS. Transmission of HIV associated with IV drug usage is more common in the minority community, as is exposure through heterosexual contact with an IV drug user. As a result, there are comparatively more black

Age	Racial or Ethnic Group		
	White, not Hispanic	Black, not Hispanic	Hispanic
13-19	48.1	31.8	20.2
20-24	50.1	30.7	18.3
> 24	73.3	16.3	10.4

Table 3: Racial or ethnic membership of AIDS cases by age: percentages.

women and Latinas diagnosed with AIDS, as compared with white women, both among adolescents and adults. There are also credible descriptive data describing the participation of adolescents in the crack cocaine subculture, in which the exchange of sex for drugs appears to be a significant route for the transmission of infections.

It is important, however, to avoid mislabeling minority youths as a group at high risk of becoming infected with HIV. Because many minority youths do live in areas of concentrated poverty in central cities, these specific youths are, indeed, at high risk of exposure to HIV. But the prevalence of risk-taking behavior among minority youths varies greatly across subgroups within this population. For example, it is apparently a well-kept secret that use of alcohol and every other drug is less prevalent among blacks than whites among high school seniors.

Young gay men

Over 50% of persons with AIDS diagnosed between the ages of 20 and 24 are males reporting a homosexual contact that could have exposed them to HIV. These data indicate that gay adolescents are a group at high risk of infection. This statement may seem inconsistent with the evidence that many gay men have reduced their participation in risky sexual behaviors such as unprotected anal intercourse. However, the data on AIDS risk-taking among gay men, although they reflect real and impressive behavior change and give great encouragement to the AIDS prevention community, need to be interpreted with caution.

The evidence for behavior change comes primarily from large cohort studies, that is, research projects in which a group of men is enrolled at some date and followed for several years. Although these studies have reported large reductions in the rates of risk-taking behavior, there have always been small groups that do not change their behavior and others who relapse. Even more important, it is difficult to infer the cause of behavior change from a cohort study. On the one hand, it is possible that the apparent size of the behavioral changes resulted in part from the early deaths of those most committed to risk-taking behavior. On the other hand, one must ask whether the sexual norms of the first gay cohort exposed to AIDS changed simply because the men became educated about AIDS, or was the change also a result of the psychological maturation of these men as they aged? These uncertainties – which are intrinsic to longitudinal research and are well recognized by the scientists involved – make it difficult to generalize the results of AIDS prevention studies with older gay men to contemporary gay adolescents.

With this background, it may be less surprising to learn that while older gay men in urban areas have decreased their rates of sexual behaviors that can transmit HIV infection, there are now several studies showing that many young gay men continue to engage in unsafe intercourse. The most frightening example is a report from the Young Men's Survey conducted by the San Francisco Department of Public Health. This research team interviewed a small sample of gay teenagers found in settings frequented by young gay men. Researchers from the Center for AIDS Prevention at the University of California San Francisco report that 43% of these teenagers had practiced unprotected anal intercourse in the last 60 days. The disturbing conclusions from these and other studies are (a) that HIV infection may still be spreading rapidly among young gay men and (b) that the lessons about safe sexual behavior learned by older gay men may have little influence on gay adolescents.

Summary

The data about AIDS prevention among adolescents are incomplete: in particular, we need more information about the success of prevention efforts among runaways and high risk minority youths. Nevertheless, it is clear that to this point *prevention of risky behaviors related to HIV infection among adolescents is* not *working*. Although information about AIDS has persuaded many gay men to avoid risky sex, both heterosexual and homosexual adolescents continue to practice risky sexual behaviors.

How to do (and how not to do) prevention among adolescents

Adolescents have been recognized as being at risk for HIV infection for several years. The evidence reviewed above indicates, however, that efforts to prevent AIDS risk-taking behavior among adolescents are failing. We need to consider why it is difficult to prevent AIDS risk-taking among adolescents and what we could do that would help prevent HIV infection in this group.

The primary reason for the failure of AIDS prevention among adolescents, I believe, is that most efforts have been limited to brief efforts to provide information about AIDS risks. It appears that these efforts have successfully informed many adolescents. Surveys show that overwhelming majorities of adolescents know that AIDS is lethal and can be acquired through unprotected intercourse or use of intravenous drugs. But the experience from prevention efforts for many other types of risk-taking among adolescents shows that having accurate information is a necessary but by no means sufficient basis for preventing youths from practicing risky behaviors.

Why do adolescents take risks even when they are informed about the dangers of their behavior? Adolescents, particularly those who are alienated from their families, will be vulnerable to adults who offer affection in return for sex. Many data suggest that adolescence is also a period when we are psychologically predisposed to accept risks. There are many ways to rationalize a course of action through beliefs that exempt one from danger: for example, many young gay men apparently believe AIDS is a risk for older gays. Such

wishful thinking will not be contradicted by a young person's experience: the long delay between HIV infection and the development of AIDS symptoms means that risky behavior has few immediate consequences and that one will rarely see a peer with AIDS.

Perhaps the greatest difficulty is that there are many cultural norms that obstruct safe sex behavior. For example, many heterosexual and homosexual gay adolescents feel that condom use is incompatible with romantic love, or believe that having a primary partner exempts them from the need to use protection. Consider also that from a young age American children hear well-crafted messages telling them that sexual and romantic success is the foundation of personal satisfaction and self-esteem. Is it surprising that adolescents decide that messages about safe sex apply to someone else? Please hold in your mind the image of one of the rich, glamorous, and self-confident singles who make their trysts on television. Now try to imagine this person worrying about AIDS.

How could AIDS prevention be more effective?

It is possible to prevent risk-taking behavior among adolescents, but it takes a serious commitment. It is necessary to go beyond providing information about risk, and to look for ways to change the complex of norms, beliefs, and peer culture surrounding risk-taking behavior. Experience from efforts to prevent substance abuse, teenage pregnancy, smoking, and delinquency makes the following points clear:

1. Preventive education should begin early, before risk-taking behaviors begin.
2. The intervention must be persistent, with messages delivered through many channels.
3. The intervention should be comprehensive, addressing all adolescent risk-taking behaviors.
4. The intervention should include social skills training, to help the adolescent cope with peer cultural support for risk-taking.
5. When adolescents are already participating in high-risk behavior, they need intensive individualized attention to address the particular complex of circumstances and beliefs that maintain that behavior.

There are also several specific problems with AIDS prevention that must be addressed.

1. Little is known about adolescent sexual practices or what they mean to youths. *Development of effective, theory-based interventions requires support for basic research on adolescent behavior, and sexual behavior in particular.*
2. Although we should design interventions for young adolescents and pre-adolescents that will delay the initiation of adult behaviors like alcohol use and sexual intercourse, it is futile and dangerous to deny that the great majority of adolescents are sexually active by the end of high school. *We must face the responsibility of teaching these youths that if they are sexually active they must protect themselves with condoms.*

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3. The adolescents at greatest risk – gay adolescents, runaways, and underclass, delinquent youths – are stigmatized, alienated, and difficult to reach through traditional school or public health interventions. *There must be expanded funding for innovative, research-based, programs to deliver prevention services to these groups.*

Acknowledgments and References

The data in Tables 1 and 3 are derived from the CDC's May 1991 *HIV/AIDS surveillance report*, the percentages in Table 3 do not include other minority groups. Data in Table 2 are from the 4 January 1991 *Mortality and Morbidity Weekly Report*, also published by the CDC. For a better understanding of these issues, and perspective on the severe limits of our knowledge about adolescents and AIDS, it is important to study the original scientific literature. Please contact me for a list of the references that document the research upon which this testimony is based.

Several noted researchers helped me prepare this testimony: Dr. Sevge Aral of the Centers for Disease Control; Drs. Robert Hays, Susan Kegeles, and Ron Stall of the Center for AIDS Prevention Studies, University of California, San Francisco; Dr. George Lemp of the San Francisco Department of Public Health AIDS Office; Dr. Shanna Millstein of the Department of Pediatrics, University of California, San Francisco; Dr. Gary Remafedi of the Adolescent Health Program at the University of Minnesota School of Medicine; and Dr. Brian Wilcox of the American Psychological Association.

Chairwoman SCHROEDER. Thank you very much.

Well, our next witness this morning is very well positioned. Maybe we can have some information as to why we don't have more up-to-date data, but Dr. Kolbe, we welcome you, and the floor is yours.

We will submit all of your testimony for the record and feel free to summarize or whatever.

STATEMENT OF LLOYD J. KOLBE, PH.D., DIRECTOR, DIVISION OF ADOLESCENT AND SCHOOL HEALTH, CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH DEPARTMENT, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ATLANTA, GA

Mr. KOLBE. Thank you, Madam Chairperson and Members of the committee.

I am Lloyd Kolbe, Director of the Division of Adolescent and School Health, a division of CDC's National Center for Chronic Disease Prevention and Health Promotion.

I am happy to have this opportunity to address important health risks among youth.

In my written testimony, I have described some of CDC's efforts to prevent risks among youth and have responded to questions that Chairwoman Schroeder posed in her letter.

I would be pleased to provide more detailed information following my oral remarks. For my oral summary, let me highlight for you the most significant health problems we, as a Nation face, and suggest one important and, I think, neglected solution.

Among young people aged one through 24, almost 70 percent of all deaths is due to only four causes. Motor vehicle crashes account for 33 percent of all of those deaths, other unintentional injuries account for about 15 percent, suicide for 10 percent, and homicide for 10 percent.

These deaths are largely preventable and result from a small number of behaviors that usually are established during childhood and adolescence.

For example, about half of all deaths from motor vehicle crashes could have been prevented if those involved had worn seat belts. Further, about half of all deaths from motor vehicle crashes among teenagers involved a teenaged driver using alcohol or drugs.

Significantly, alcohol and drug use contribute enormously to other unintentional injuries, as well, and to injuries intentionally inflicted, including homicide and suicide.

Though alcohol and drug use may not be listed among the leading causes of mortality and morbidity in this age group, these behaviors certainly are major contributors.

Similarly, sexual behaviors established during youth contribute to significant disease, social problems, and now since the advent of the HIV epidemic, AIDS. One million teenagers become pregnant every year and five of every six pregnancies among 15 to 19 year olds are unintended.

In addition, every year about two-and-a-half million U.S. teenagers are infected with a sexually transmitted disease. AIDS has become the sixth leading cause of death for 15 to 24 year olds.

As Dr. Gardner testified, nearly 20 percent of all AIDS cases have been reported among persons 20 to 29 years of age. Because of the lengthy period between infection with the human immunodeficiency virus and the onset of AIDS, we know a significant portion of those persons acquired their infection in their teenage years, and those infections are the result of risk behaviors practiced by teenagers.

In our analysis of health risk for youth, we also identified the two health problems most likely to plague them later in life, cardiovascular disease and cancer.

Almost 60 percent of all deaths in the Nation are attributable to these two causes, and three behaviors contribute greatly to these diseases: tobacco use; improper diet, such as excessive consumption of fat; and inadequate physical activity.

CDC believes that one of the most efficient ways to prevent all of these risk behaviors is through planned and sequential, kindergarten through grade 12, comprehensive school health education programs.

These programs integrate education with a range of often interrelated health risk behaviors at developmentally appropriate ages, and these programs help young people develop the decision-making, communication, and peer resistance skills they will need to avoid risk behaviors.

As I have described more fully in my written testimony, though CDC has designed its current efforts principally to prevent behaviors that result in HIV infection among youth, these efforts can be adapted to address other priority risk behaviors as well.

CDC, as the Nation's prevention agency, is committed to working with the Nation's schools and other agencies that serve youth to implement comprehensive health education and other programs to prevent priority risk behaviors.

Our commitment is to address a wide range of risk behaviors, including tobacco use, dietary patterns, sexual behaviors that result in HIV infection and other sexually transmitted diseases, and other behaviors that result in preventable disease, injury, and death.

We are addressing risk behaviors currently in partnership with relevant national, state and local education and health agencies, and we as a Nation must be effective in preventing these risk behaviors.

The very lives and well-being of our youth, our future, depend on it.

This concludes my prepared remarks. I would be glad to respond to any questions that you or any other of the committee Members may have.

[Prepared statement of Lloyd J. Kolbe follows:]

PREPARED STATEMENT OF LLOYD J. KOLBE, PH.D., DIRECTOR, DIVISION OF ADOLESCENT AND SCHOOL HEALTH, CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ATLANTA, GA

Madame Chairperson, and Members of the Committee, I am Lloyd Kolbe, Director of the Division of Adolescent and School Health, a division of CDC's Center for Chronic Disease Prevention and Health Promotion. I am pleased to have this opportunity to highlight CDC's recent efforts to prevent important health risks among youth.

We know that school health education can prevent these risks. Our evaluations show that education programs in elementary schools deter smoking among seventh-graders. A recent large scale study established that school health education programs can have significant effects on knowledge, attitudes, and risk behaviors among high-school students as well. Study results confirmed that exposure to such programs had a positive effect on curbing illegal drug use and tobacco use.

In November 1988, CDC established the Division of Adolescent and School Health to assess the health risks facing America's youth and to implement national programs to promote and protect their health. I will describe these risks and some of CDC's efforts to prevent them.

Among young people aged 1 through 24, almost 70 percent of all deaths is due to only four causes: motor vehicle crashes account for 33 percent of all deaths; other unintentional injuries cause

15 percent; homicide causes 10 percent; and suicide causes 10 percent.

These deaths are largely preventable and result from a small number of behaviors that usually are established during childhood and adolescence. For example, about half of all deaths from motor vehicle crashes could have been prevented if those involved had worn seatbelts. Further, about half of all deaths from motor vehicle crashes among teenagers involved a teenage driver using alcohol or drugs. Significantly, alcohol and drug use contribute enormously to other unintentional injuries as well, and to injuries intentionally inflicted, including homicide and suicide. Thus, although alcohol and drug use may not be listed among the leading causes of mortality and morbidity in this age group, these behaviors are certainly major contributors.

Similarly, sexual behaviors established during youth contribute to significant disease, social problems, and now (since the advent of the HIV epidemic) death. Five of every six pregnancies among 15 to 19 year olds in the U.S. are unintended; over 23,000 teenagers 14 years or younger become pregnant each year. In addition, every year, 2.5 million U.S. teenagers are infected with a sexually transmitted disease. The number of reported AIDS cases in the U.S. in adolescent females aged 13-19 increased a startling 71 percent from September 1989 to September 1990. AIDS

has become the sixth leading cause of death for 15 to 24 year olds. Nearly 20 percent of all AIDS cases have been reported among persons 20 to 29 years of age. Because of the lengthy period between infection with the human immunodeficiency virus and the onset of AIDS, we know a significant proportion of those persons acquired their infection in their teenage years, and that those infections are the result of risk behaviors practiced by teenagers.

In our analysis of health risks for youth, we also identified the two health problems most likely to plague them later in life: cardiovascular disease and cancer. Almost 60 percent of all deaths in the nation are attributable to these two causes. Three behaviors contribute greatly to these diseases: tobacco use, improper diet (such as excessive consumption of fat), and inadequate physical activity.

Monitoring Health Risks Among Youth

The CDC Youth Risk Behavior Surveillance System (YRBSS) monitors six priority health risks: (1) sexual behaviors resulting in HIV infection, other sexually transmitted diseases, and pregnancy; (2) alcohol and drug use; (3) tobacco use; (4) dietary patterns resulting in disease; (5) lack of physical activity; and, (6) behaviors resulting in unintentional and intentional injuries. The YRBSS is a single survey instrument that young people can complete,

with parental permission, to anonymously report their risk behaviors in these six areas. This instrument allows assessment of the extent to which these behaviors are inter-related, and significantly, the use of a common survey instrument also allows for state-to-state comparisons. The YRBSS also allows us to track progress in achieving 22 of the National Year 2000 Health Objectives related to youth health risk behaviors.

In the spring of 1990, we surveyed a national sample of 9th through 12th grade students. Simultaneously, approximately 30 state education departments and 8 local departments of education administered the survey to a sample of 9th through 12th grade students in their respective jurisdictions. The results of this survey are useful to these states and cities in assessing the extent to which young people in their <u>own</u> areas are at risk for major health problems, and are valuable in implementing programs to reduce these behaviors. Although these survey results are still being analyzed, we do have results from our 1989 national survey of risks related to HIV: 57 percent of the nation's 9th through 12th grade students reported having engaged in sexual intercourse, 22 percent reported four or more sexual partners, and 3 percent reported illicit drug injection. With the Committee's permission, I am providing for the record an article published in the journal, <u>Family Planning Perspectives,</u> summarizing some of the results from this survey.

Prevention Programs

As the nation's prevention agency, CDC is helping the nation's schools and other agencies serving youth implement effective programs. To prevent the behaviors that result in HIV infection, CDC supports: (1) 24 collaborating national organizations (e.g., Council of Chief State School Officers, National Association of State Boards of Education, National PTA, National Network of Runaway and Youth Services); (2) every state, five territorial, and 16 large city departments of education; (3) three training centers that have trained over 500 state and local agency staff to implement effective health education programs; (4) an information development and dissemination system; (5) a surveillance system (that includes the YRBSS as one of its elements); and (6) an evaluation system. As part of our effort to address minority youth, CDC funds and works with the Coalition of Hispanic Health and Human Services Organizations, the National Organization of Black County Officials, and the Indian Health Service.

In 1990, the General Accounting Office (GAO) recommended that CDC: 1) increase HIV education for 11th and 12th grade students, 2) help smaller school districts implement HIV education, 3) ensure that state and local grantees collect adequate data about student risk behaviors, and 4) develop guidelines for training

teachers to implement HIV education. CDC has addressed each of these recommendations in FY 1991 by requesting that funded national organizations, and state and local education agencies, address these four issues in their continuation applications. In addition, in response to the 1990 Senate Appropriations Committee's direction, CDC redirected HIV education resources to establish 24 new regional centers administered by the states to train teachers to implement comprehensive school health education curricula, including HIV education.

Although CDC has designed its current program principally to prevent behaviors that result in HIV infection among youth, it can be adapted to address other priority risk behaviors. Rigorously conducted studies have shown that planned, sequential, and age-appropriate health education in schools can be effective in reducing the prevalence of health risk behaviors. One specific finding revealed that school health education programs resulted in a 37% reduction in the onset of smoking among seventh-grade students. To be most effective, school health education integrates a range of important health concerns and provides youth with the decision-making, communication, and peer-resistance skills needed to avoid risk behaviors.

The Report of The Presidential Commission on the Human Immunodeficiency Virus Epidemic, published in June 1988, states,

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"The Commission strongly believes that the introduction of an age-appropriate comprehensive school health education curriculum that encompasses grades K through 12 is long overdue. Providing our nation's school children with education about HIV transmission . . . is a significant step. However, it represents only a stop-gap measure to correct a larger problem." Indeed, one of the National Health Objectives states that by the Year 2000 the nation should "Increase to at least 75 percent the proportion of the nation's elementary and secondary schools that provide planned and sequential kindergarten through twelfth grade quality school health education."

CDC's Guidelines for School Health Education to Prevent the Spread of AIDS, developed in collaboration with a host of national health and education organizations, have assisted health and education agencies to plan and focus HIV prevention efforts appropriate to the needs of their jurisdictions. CDC currently has no plans to revise these guidelines. They suggest content that may be appropriate for youth at various grade levels, but suggest that "the exact grades at which students receive this information should be determined locally in accord with community and parental values, and thus may vary from community to community."

As you know, some youth are more likely to engage in risk behaviors than others. Among young people in high-risk situations are runaway and homeless youth, gay and lesbian youth, youth who are not in school and are unemployed, juvenile offenders, youth who require mental health services, and others. CDC has recently launched a new program to intensify efforts to prevent HIV infection and other related health problems among these young people. By October of 1991, CDC will have provided financial assistance to local health departments in approximately 3 of the nation's largest cities to intensify efforts to prevent HIV infection and other important health problems among high-risk youth. These agencies will integrate their efforts with services provided by other city agencies serving high-risk youth (e.g., sexually transmitted disease clinics, alcohol and drug abuse programs, and job training). In addition, CDC will provide funding to one of the three selected cities to train staff from other cities that are interested in replicating their efforts.

Evaluation of Efforts

CDC is committed to evaluating the impact of its HIV education efforts. Evaluation provides a measure of accountability for resources, and also determines what works, what doesn't, and why, so that intervention efforts can be improved. CDC's evaluation activities include monitoring the percentage of schools that provide, and students that receive, HIV education, and the incidence and prevalence of risk behaviors. In addition, CDC

conducts research to measure the effectiveness of education programs in preventing behaviors resulting in HIV infection and other important health problems. Numerous HIV education programs have been developed for youth. Evaluating a program is a lengthy and expensive process. CDC is in the process of evaluating several HIV education programs, and has published a request for proposals to evaluate others. However, CDC currently is not evaluating the HIV/AIDS and the sex education components of the Teenage Health Teaching Modules.

In closing, I would like to thank the Committee for its interest in risk behaviors among youth. We at CDC believe that the nation's schools, and other agencies serving this population, can be highly effective in helping keep our youth safe from the multiple epidemics they face. Basic to preventing the establishment of risk behaviors among youth are:

- the involvement of families, young people themselves, and their communities in planning and implementing risk reduction programs; and

- a collaborative effort between the institutions responsible for the health of youth, and those responsible for their education.

CDC, as the nation's prevention agency, is committed to working with the nation's schools, and other agencies that serve youth, to implement comprehensive health education and other programs to prevent priority risk behaviors. Our commitment is to address a wide range of risk behaviors including tobacco use, dietary patterns, sexual behaviors that result in HIV infection and other sexually transmitted diseases, and other behaviors that result in preventable disease, injury, and death. We are addressing risk behaviors in partnership with relevant national, state, and local education and health agencies. We as a nation must be effective in preventing these risk behaviors. The very lives and well-being of our youth, our future, depend on it.

This concludes my prepared remarks. I will be glad to respond to any questions you or other members of the Committee may have.

Chairwoman SCHROEDER. Thank you very, very much. We appreciate that.

Our next witness is Dr. Rotheram-Borus. I hope I got that right, Mary Jane. But anyway, welcome, and we will put your full testimony in the record, and the floor is yours.

STATEMENT OF MARY JANE ROTHERAM-BORUS, PH.D., ASSOCIATE PROFESSOR, DIVISION OF CHILD PSYCHIATRY, COLUMBIA UNIVERSITY, NEW YORK, NY

Dr. ROTHERAM-BORUS. Thank you, Madam Chairwoman and committee Members.

Today, I am here to talk to you about the effectiveness of an HIV prevention program with runaway and gay youth in New York City, a cohort of 450 youths which was started about three and a half years ago.

There are estimated to be 1.5 million runaways in the United States of whom the estimated sero-prevalence rates have ranged from a low of 2.1 percent in Houston to a high of 5.3 percent already HIV infected in New York City. Among gay males, we have no estimate because, as you just heard, our information is about 20 years old. But up to 10 percent of adolescents may self-identify as gay, and in our own study, the estimated prevalence of HIV is about 16 percent among minority gay adolescents in New York City under the age of 18.

When you begin to talk about HIV among these very high-risk groups, HIV is, first, only one problem among many. These adolescents, runaway and gay youth, have been victimized. Family problems led to 10 percent of them being thrown out of their homes and over 65 percent of the families are characterized by severe dysfunction. Fifty percent of the parents are alcoholics or have been in jail in the last six months. Fifty-seven percent of the adolescents have gone at least one day without food, and the estimates of sexual abuse among runaways ranged between 25 to 60 percent.

Among gay youth in our sample, more than 55 percent had reported violence against them, gay bashing, because they were gay-identified, and 12 percent have been thrown out of their homes. So that, while being victims, these youth now have a cluster of behavior problems that put them at risk for multiple negative outcomes in addition to HIV. Fifty percent have trouble at school. Forty-five percent of the gay adolescents have tried to kill themselves and 33 percent of the runaway girls have also attempted suicide.

Teenage pregnancies are a problem—23 percent of the runaway girls have been pregnant in the last three months. Twenty-eight percent use crack cocaine, a drug directly related to HIV, and more than 90 percent have used alcohol.

The second point that I would make is that our stereotyping of these youth is inaccurate in two ways. First, we have unrealistic and exaggerated fantasies of what their sexual lives are like. There are subgroups within high risk groups which account for most of the high risk acts. In the last three months, 25 percent of both runaways and homeless youths, as well as the gay youth, have been abstinent. On average, the median number of sexual partners is

one for girls—and for boys there have been three to four partners in the last three months.

There is a subgroup of about 25 percent of the gay and the runaway males who have traded sex for money and drugs, and about 21 percent of these youth have more than three sexual partners, more than 10 sexual occasions and inconsistent condom use in the last three months.

Among the gay youth, 52 percent are having sex with girls, and more than three-quarters have had anal receptive intercourse, the highest risk act for HIV transmission. So that these youths are engaging in a substantial number of risk acts. These risk acts are really among about a quarter of the runaway and gay youth.

These data have led authors, for example, in *The Journal of American Medical Association* a year ago to conclude that the number of problems and the extent of the problems are "so overwhelming" that they tend to "depress and demoralize us, to make us feel that we can do nothing" to impact the problem.

Over the last three and a half years, as we have instituted an intensive HIV prevention program in five runaway shelters in New York City and we have examined the outcome data for the first 145 runaways and the first 110 gay youth, we are finding significant increases in consistent condom use among these youth and showing significant decreases in the percentage of youths reporting a high risk sexual behavior pattern.

The impact of the program is directly related to the intensity, so that the more sessions youth receive, the more skills training that these youths receive, the greater change in their behavior. If we look at the three months prior to the implementation of the program among the runaways, consistent condom use was reported by 18 percent of the youth. Six months later, by those receiving 15 or more sessions, 62 percent reported consistent condom use.

During the three months prior to the program 21 percent reported what we call a high risk pattern—inconsistent condom use and more than three sexual partners. Six months later we had no youths who had received 15 sessions or more reporting such a high risk pattern.

Among gay youth, the results are similar, except for those who are showing psychiatric disturbance, who appear more psychiatrically disturbed.

Both fortunately and unfortunately, our findings are not unique. They parallel the results of intensive intervention efforts that have been mounted with adult gay men. They also parallel the findings of intensive prevention efforts that have been successfully managed for smoking prevention, substance abuse prevention and teenage pregnancy.

Successful programs are typified by a number of characteristics. First, they are always delivered in the context of comprehensive health care. Second, they build on youths' strengths. Third, they involve active rehearsal, repeated rehearsal of the kinds of skills that are going to be necessary in high risk situations to implement safe acts. Fourth, they are delivered in a context of social support from peers and institutional support in their local communities. And, lastly, they are intensive. They are not two to three sessions of educational sessions (which is what most communities in the United

States are struggling to mount). They are about five times this dosage.

Where do these data lead us in terms of policy implications? First, the kind of HIV programs we need must build on those successfully demonstrated for other high-risk adolescent behaviors like substance abuse. But there is a big gap between demonstration and dissemination. There has been no broad scale dissemination of such intensive programs for any of the high risk acts.

Currently the Centers for Disease Control is funding Safe Choices conducted by the National Network of Runaway and Youth Services, a program for national dissemination of HIV to runaway and homeless youth networks. This program is funded, however, to provide two or three days of training to staff and then these staff are expected to go back home and to implement an intensive program. While an outstanding training model is available, it is not funded at a level that could realistically allow effective dissemination.

Second, the HIV epidemic is changing, and we need to change our programs with it. Perhaps this is clearest around the issue of HIV testing with adolescents. HIV testing is increasingly advocated because of the hope for prophylactic treatments for early detection. However, no resources are associated with the increased demand for testing, so that many problems emerge. A case that we had in our office a few weeks ago demonstrated the problems.

We had a 19-year-old black female who found out the day before that her boyfriend and father of her 15-month old and six-month old babies was infected with HIV. She had been tested for HIV that morning, and she showed up for a research interview, not for any kind of clinical appointment. She was suicidal. She needed to be psychiatrically hospitalized. But in the course of it we found out that: 1) she had been only given an appointment three weeks later; 2) she had asked three times, but it wasn't clear to her whether her babies needed to be tested or not; 3) she did not have any condoms, and she had been at a testing site that morning and with her boyfriend at an HIV testing site the day before; and 4) her boyfriend had seen a doctor the day before and that day. He had an abscessed finger which necessitated overnight hospitalization, but it had not been treated by any of the doctors.

This gap between ideal delivery of health care services and actual services delivered, particularly to adolescents, is substantial. If adolescents test positive, they do not have any access to services. In addition, adolescents would not necessarily utilize services if they did have access. Adolescents are likely to be stigmatized and are unrealistic about the stigmatization. It is very unclear that even if adolescents tested HIV positive that they would be motivated and able to change their risk behaviors. As I mentioned earlier, 43 percent of the gay youth have attempted suicide in the past. In a study in New York City among adolescents enrolled in school 21 percent said they would kill themselves if they tested HIV positive. So we need to do some long term natural history studies of adolescents who find themselves HIV positive.

The second recommendation is the importance of stabilizing the lives of high-risk youth. Why would a runaway or homeless youth care about getting HIV and dying ten years from now when they

do not know where their bed is tonight or where their next meal is going to come from? In the last six years, foster care resources and beds have decreased 27 percent. However, the number of youth needing foster care has increased 25 percent. Again, there is a gap between what we need and what we have.

Third, our levels of family support for single parent, impoverished, and dysfunctional families has been an inconsistent policy at best. Since most of the runaway youth emerge out of dysfunctional families, and running away and homelessness are associated with family problems, it is critical that we have some kind of coordinated family policy.

And, finally, gay, sexually-abused, and substance-abusing youths again have no resources for specialized programs. For example, last Friday a crack addicted adolescent wanted treatment. We could not find a bed in New York City for over eight hours and then only by utilizing personal favors. We had to go to five community-based agencies to get birth certificates and evidence of housing before we could get her in a program for crack and substance abuse. There are no substance abuse treatment facilities for adolescents. In summary, unless we begin to look at HIV within the context of comprehensive care for adolescents, we will fail.

PREPARED STATEMENT OF MARY JANE ROTHERAM-BORUS, PH.D., PRINCIPAL INVESTIGATOR OF THE ADOLESCENT PREVENTION STUDIES UNIT, HIV CENTER FOR CLINICAL AND BEHAVIORAL STUDIES AND ASSOCIATE PROFESSOR OF CLINICAL PSYCHOLOGY, DIVISION OF CHILD PSYCHIATRY, COLUMBIA UNIVERSITY AT THE NEW YORK STATE PSYCHIATRIC INSTITUTE, NEW YORK, NY

Summary of Recommendations

1. Disseminate HIV preventive services on a broad scale.

2. Conduct prospective studies of HIV testing, and develop pre- and post-test counseling procedures tailored to adolescents.

3. Provide adequate funding for both temporary residential and long-term independent living programs.

4. Provide realistic levels of support for single-parent, impoverished, or dysfunctional families.

5. Develop, disseminate and expand specialized intervention programs for gay, sexually-abused, and substance-abusing youths.

Introduction

My name is Mary Jane Rotheram-Borus. I am the Principal Investigator of the Adolescent Prevention Studies Unit of the HIV Center for Clinical and Behavioral Studies supported by an award from the National Institute of Mental Health and the National Institute on Drug Abuse. I am an Associate Professor of Clinical Psychology in the Department of Child Psychiatry at Columbia University in New York and a research scientist at the New York State Psychiatric Institute. For fifteen years I have specialized in developing and evaluating prevention programs targeting adolescents.

Madame Chair and committee members, thank you for inviting me to speak. I am here to discuss successful HIV/AIDS prevention programs for adolescents. My remarks are based on an HIV/AIDS prevention program that evaluated with 450 youths in New York City at high risk for becoming HIV infected - 300 runaways and 150 gay male adolescents.

Barriers to Successful HIV/AIDS Prevention for Adolescents

The importance of developing effective HIV/AIDS prevention programs for these two groups is underscored by the numbers of these youths in the U.S. and their estimated HIV infection rates. Among an estimated 1.5 million runaways, approximately 4%, or 60,000 are estimated to be infected. Among gay males, estimated to be 9-14% of all males, estimates of seroprevalence range up to 15%.
However, HIV infection is only one problem among many for these youths. They are often victims. Among runaways, approximately 10% are thrown out of their family homes; 50% have parents who are either alcoholics or in jail, 57% have gone without food for at least one day in the past month, and 25-60% have been sexually abused. Among gay male adolescents, approximately 80% have experienced gay bashing, and 12% have been thrown out of their family home.

Given the stressors in these youths' lives, it is not surprising that many develop a cluster of behavior problems, putting both themselves and others at risk. Approximately 50% have trouble at school, many are depressed and suicidal (43% of gay male youths and 33% of runaways), 25% become involved in teenage pregnancy, 90% use alcohol, 41% use marijuana, and 28% use crack/cocaine.

However, it is important to clarify two ways in which the stereotypes of these youths are inaccurate. First, the stereotypes inaccurately exaggerate the risk acts of these youths. The stereotypes do not focus on the fact that 25% of these youths are sexually abstinent, on the fact that female runaways typically have been sexually involved with only one partner in the past three months, with males typically involved

with 2-4 partners in the same time period, and that their condom use is similar to that of adolescents in general. Furthermore, only about 20% are engaged in a high risk pattern of unprotected sexual activity with more than two partners or on more than 10 occasions or in exchanging sex for money or drugs.

A second inaccurate stereotype is that these youths cannot change, leading a reviewer in an article in the Journal of the American Medical Association to conclude that these youths have a "bleak and hopeless future" and have problems that tend to overwhelm, depress, and demoralize us, leading to a belief that "The problem is so huge, so inevitable; nothing can be done."

In fact, the research shows that these youths do change. In analyzing the effects of an intensive HIV/AIDS prevention program on 145 runaways and 110 gay males over six months, we found improvements in consistent condom use and a high risk pattern of sexual behavior, but no increase in abstinence. Furthermore, we found that among runaways improvements were greatest for those receiving 15 or more sessions of the intervention, who increased their consistent condom use from 21% to 62% and decreased in the pattern of high risk sexual behavior from 21% to 0. Among the gay male youths, we found that among those who exhibit psychiatric disturbance, their risk behaviors are the most difficult to change.
These findings are not unique. Successful behavior change in response to intensive interventions have been reported among adult gay men, and in teenage pregnancy, smoking, and substance abuse prevention programs. These programs share several characteristics: a) interventions are provided in the context of making available comprehensive health care services and other community resources; b) they build on participants' strengths rather than merely targeting deficits; c) they engage participants in active rehearsal of the targeted health-enhancing behaviors; d) social support from peers in the environment reinforces learning; and the interventions are intensive, providing, for example, 15 or more sessions instead of merely 2-3 hours of educational interventions.

Recommendations[1]

HIV Interventions for Adolescents

While the success of this HIV/AIDS prevention model has been demonstrated, it needs to be disseminated nationally to prevent HIV infection among adolescents. Perhaps this is most clearly seen in the lack of adequate programs targeting HIV-positive youth. Just last Friday a 19-year old Black female appeared in my office with her boyfriend and father of her two children, 15 months and 6 years old. She had become suicidal in learning that her boyfriend was HIV-positive, did not know whether to get her children tested, and had just gotten herself tested for HIV that

morning and had no follow-up counseling scheduled until three weeks later. She and her boyfriend did not have condoms, and he needed immediate emergency care for an abscessed finger. These youths illustrate the inadequacy of policies that advocate HIV testing without providing adequate support services. Such youths do not realize the stigmatization likely to follow their disclosure of their serostatus, are unclear in their motivation to change their behavior, and may react precipitously by attempting suicide.

Preventing the spread of HIV among adolescents requires more than anonymous and confidential HIV testing. If initiated immediately, several steps could alleviate the spread and other negative effects of HIV infection among homeless youth:

a) Fund the implementation of HIV prevention programs in temporary shelters, foster care, group homes, and other social service agencies. In these programs, address, in addition to AIDS knowledge and attitudes, the acquisition of skills and the establishment of social support networks that are necessary to maintain safe acts.

b) Provide comprehensive care to HIV-positive adolescents that includes provision of case managers, and specifically target homeless youth, such as by allocating funding under the Ryan White AIDS Care Act.

c) Remove federal and state impediments to homeless youths' participation in AIDS drug trials, particularly the requirement of parental consent.

d) Conduct descriptive studies of the impact of HIV testing on adolescents, specifically examining the effect of testing on behavior change, and evaluate strategies for pre- and post-test counseling that consider youths' developmental capacities, their low compliance to health care regimens, and their scarce family and peer resources.

Temporary Shelter and Independent Living

To avoid risk behaviors that can lead to HIV infection, adolescents need first to have stable lives. What do they care about HIV six years from now when they lack a bed for tonight?

When the first Runaway and Homeless Youth Act of 1974 was funded, shelter was provided for 15 days and provisions were made allowing for "full service" agencies. Youth shelters were staffed with social workers, crisis counselors, public health nurses, and were compensated to network with local hospitals, outpatient clinics, and schools. Today, these full-service agencies are rare, due to lack of comprehensive funding, with only a few executive directors managing to creatively piece

together local, state, and federal funding to approximate the network of services required. Some communities, particularly in rural areas, fall far short of approximating a full-service model.

Even more problematic, due to the limited availability of temporary housing, homeless youths often must be discharged to the streets. Without fundamental reordering of priorities, the foster care system will fail to adequately serve youths.

Finally, the question of continuity of care for 18 year old adolescents who age out of the foster care system, but lack the skills to live independently or to hold a job, remains unaddressed in many states. Exemplary models of independent living programs have been demonstrated, yet substantially more funding is required to provide for the numbers of youths needing these services.

Family Advocacy

The dramatic changes in the structure and diversity of American families over the last 20 years have not been reflected in governmental and employers' policies regarding families. The failure to have a supportive and functional family is the single largest factor associated with adolescent homelessness. Family problems take many different forms (e.g., parental substance abuse, family homelessness, health problems, social isolation), and adolescents in dysfunctional families are often better served by leaving these homes rather than attempting to resolve insolvable problems with few resources.

The number of youths leaving untenable home situations is reflected by the 370,000 youths currently in foster care and group homes, expected to escalate to 840,000 youths by 1995. The magnitude of this problem suggests that individual solutions are inadequate for youths trying to cope with families under stress. Unless families under stress receive additional support, many youths will leave, becoming homeless. To reverse the rising tide of adolescent homelessness, families need basic guarantees of housing and employment. In addition, families under stress and parents with a history of substance abuse need assurance that they have access to treatment and social services.

Services for Gay, Sexually-Abused, and Substance-Abusing Adolescents

For adolescents receiving temporary shelter, the family's rejection of the youth's lifestyle may be the most common precipitant of being ejected from the family. Specific intervention programs are needed to help such adolescents cope with the stress associated with escaping a situation of sexual abuse and neglect or acknowledging a gay sexual orientation.

When providing HIV-related interventions to gay and sexually abused youths, special recognition of the individual's barriers to implementing safe sexual behaviors is needed, as well as recognizing that these issues are highly charged emotionally.

For youths who are routinely using alcohol and drugs, it is unlikely that safe behaviors can be implemented unless their substance abuse has been eliminated. Long waiting lists remain at drug treatment centers and with the elimination of needle exchange programs, the probability of implementing effective HIV preventions declines for these youth.

Summary

In contrast to media stereotypes, homeless and gay youths are well informed about HIV and responsive to change. Rather than painting a hopeless scenario, the possibility of change among homeless and gay youths is high, and substantial opportunities exist for interventions with these adolescents. However, the long-term efficacy of the policy recommendations suggested here remain hypothetical. In a testimony recently presented to the New York Commission on HIV, one service provider summarized the situation: "We have known for a long time what to do, we have not done it. Will HIV be the crisis that gets America to treat youths in a humane manner? Will now be the time?"

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[1] These recommendations appear in a forthcoming article by M.J. Rotheram-Borus, C. Koopman, & A.A. Ehrhardt. Homeless youths and HIV infection. The American Psychologist. (In press).

Chairwoman SCHROEDER. That is not very cheerful, but very realistic.

Our final panel witness this morning is Dr. Meloy, and we are very happy to have you with us this morning. The floor is yours, and we will put your entire statement in the record.

STATEMENT OF LINDA DIANNE MELOY, M.D., FAAP, ASSISTANT PROFESSOR OF PEDIATRICS, DEPARTMENT OF PEDIATRICS, DIVISION OF GENERAL PEDIATRICS, CHILDREN'S MEDICAL CENTER, MEDICAL COLLEGE OF VIRGINIA, VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA

Dr. MELOY. Thank you very much, Madam Chairman and distinguished committee Members. I thank you for the opportunity to come here to discuss the risky business of adolescence.

My name is Dr. Linda Meloy, and I am a pediatrician who cared for indigent adolescents and their children for six years in Petersburg, Virginia, where the teenage pregnancy rate was high and sexually transmitted diseases were commonplace.

At the present I am an Assistant Professor of Pediatrics at the Children's Medical Center at the Medical College of Virginia, where I treat indigent patients, middle class patients, the faculty's children and drug-exposed infants.

The following observations are based on my personal experiences and long-standing review of the problem.

Our teenagers are facing increased risks of sexually transmitted diseases, pregnancy and arrested development, as sexual intercourse frequency has increased from 28.6 percent in 1970 to 51.5 percent in 1988. This growth is despite the increasing numbers of school-based clinics, the increased frequency with which school districts are promoting courses in family life education, and even the increased emphasis on "safe sex."

You also know the appalling statistics on the surge of sexually transmitted diseases. This explosion is also despite all the time and money which well-meaning people have invested in school-based clinics, sex education and safe sex. Over the last 10 years, a 306 percent increase in Federal funds spent on promoting sexual responsibility corresponded with a 48.3 percent increase in teen pregnancy. Risks have increased for genital herpes, hepatitis B, pelvic inflammatory disease, ectopic pregnancy, premature labor, HIV, and malignancies related to sexually transmitted diseases.

Adolescents often become involved in sexual activities to the neglect of studies, social skill development and community activities. My six years of working with this population brought me face to face with the abject social isolation of these children. They had no friends, just a series of sexual partners. Other teens, trying to "belong," drifted into the business of sex for drugs, increasing their medical needs.

In the face of all these risks, each adolescent needs a medical home to teach prevention, provide medical care and to support appropriate development. A medical home must supply health instruction to the adolescent and their parents, medical care for the acute illnesses and chronic problems, counseling, phone advice, and easy access 24 hours a day.

I believe this expertise is found not in a clinic but in the pediatrician's office, and feel that every adolescent requires this care. As they face the problems of our society, the adolescent must have the guidance which a pediatrician is trained and experienced to provide.

What benefit does this early sexual activity provide to the adolescent? I know of none. I have not had anyone tell me of any, nor have I read articles even suggesting that early sexual activity is of any benefit to the adolescent. Yet I have cried with the emotionally wounded, treated the sexually transmitted diseases, hospitalized the pelvic inflammatory diseases, and referred for infertility and cervical cancer. Girls who thought the young man who had sex with them loved them have come to my office depressed and threatened suicide when he moved on.

Just last Thursday, in the ER, I treated just such a case. A month ago a 16-year old died of an overdose of propanol because his girlfriend ended their sexual relationship.

As an adult, the sexually-active teenager often desires to conceive but cannot because of prior infections. In 1985, Clark from Toronto noted that cervical cancer is three to four times more prevalent in people with two to five sexual partners. Time, emotional pain and physical disease are the cost of premature, promiscuous sexual activity. True abstinence prevents all these problems 100 percent of the time and alleviates much of the subclinical and subconscious anxiety which is the basis of the adolescent behavioral problems we observe.

In a failed attempt to reduce teenage health problems, school-based clinics have developed since the 1970s. The clinics fall short of the comprehensive requirements of the adolescent and create false security for many parents and teenagers. The school-based clinics fragment the teen's health care because only 66 percent of the clinics are open as much as 40 hours a week. They do not provide night or weekend coverage, and only slightly over half are open in the summer.

The emergency rooms cannot reach the clinic's "health care provider" when their patients come for service. The patient has no one to call at night for questions. Duplication of medications and contradictory medical advice are often given by the different providers. Parents are not able to help in history giving or to help in administration of suggested therapy.

The cost for this fragmented partial care varies by location, from $37 per visit to $81 per visit. In comparison, a pediatrician visit is $30 and is comprehensive in nature. School-based clinics may limit the freedom of the teen and their family to choose the physician who they feel would best meet their needs. Our tax dollars could be more effectively invested in allowing the families to select a more cost-effective, comprehensive pediatric office.

In 1987, the American Academy of Pediatrics published a cautious statement regarding school-based clinics. The AAP asked for more research to be undertaken. Only eight of the subsequent studies in peer review journals used required pre and post statistics in their studies. None of these studies proved that the clinics meet their goals. In Gary, Indiana, the study found no difference between SBC and control schools in birth rates.

After reviewing Medline and Psychologic Abstracts searches on school sex education, Stout concluded in *Pediatrics* in 1989, "Our findings indicate that the expectations of altered adolescent sexual activity, contraceptive behavior and pregnancy are unlikely to be fulfilled by these programs."

In 1982, the Council on Scientific Affairs of the AMA examined SBCs and stated, "Data are not sufficient to support the universal establishment of school-based health programs."

The American Academy of Pediatrics survey in March, 1988, revealed that only one-third of pediatricians supported the school-based clinic concept.

To reduce the incidence of sexually transmitted diseases and pregnancy, the condom is suggested. The condom must be utilized during all intercourse. Sperm must not be allowed to leak over the condom, and the condom must be intact.

Dr. Thomas Elkins, Chief of Gynecology at the University of Michigan, noted that 5 to 30 percent of nonlatex condoms leaked water molecules, which are larger than herpes, HIV or wart viruses. Latex can cause severe allergic reactions, and *Consumer Reports* states that condoms have a 15 to 35 percent failure rate in preventing pregnancy.

Abstinence will ensure no transmission, and the promotion of intercourse within marriage will create healthy role models.

In the Planned Parenthood magazine, *Family Planning Perspectives* in 1990, Howard and McCabe showed that students in an abstinence-based program are five times less likely to engage in intercourse than a control group.

Our adolescents are facing health challenges which require comprehensive care. We need to assure that access to health care providers who can meet all their needs and furnish current medical and counseling information to aid them in their development to adulthood. This kind of comprehensive care can be found in a pediatrician's office. It cannot be found in a school-based clinic. Our success should not be measured by the success of sales of latex condoms but rather in increased numbers of abstinent youth, healthy and fully engaged in the real joys of the adolescent experience.

PREPARED STATEMENT OF LINDA DIANNE MELOY, M.D., FAAP, ASSISTANT PROFESSOR OF PEDIATRICS, DEPARTMENT OF PEDIATRICS, DIVISION OF GENERAL PEDIATRICS, CHILDREN'S MEDICAL CENTER, MEDICAL COLLEGE OF VIRGINIA, VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA

Madame Chairwoman, distinguished committee members, and colleagues, I want to thank you and the distinguished ranking member, Mr. Wolf, for inviting me today to discuss the risky business of adolescence. My name is Dr. Linda Meloy and I am a pediatrician who cared for indigent adolescents and their children for six years in the inner city of Petersburg, Virginia where the teenage pregnancy rate was high and sexually transmitted diseases were commonplace. At the present, I am an Assistant Professor of Pediatrics at the Children's Medical Center at the Medical College of Virginia where I treat indigent patients, middle class patients and drug exposed infants. The following observations are based on my personal experiences and a long standing review of the problem.

Our teenagers are facing increased risks of sexually transmitted diseases, pregnancy, and arrested development as sexual intercourse frequency has increased from 28.6% in 1970 to 51.5% in 1988. This growth is despite the increasing numbers of school based clinics, the increased frequency with which school districts are promoting courses in family life education, and even the increased emphasis on "safe sex." You also know the appalling statistics on the surge of sexually transmitted diseases. This explosion is also despite all the time and money which well meaning people have invested in school based clinics, sex education, and safe sex. Over the last ten years, a 306% increase in federal funds spent on promoting sexual responsibility corresponded with a 48.3% increase in teen pregnancy. Risks have increased for genital herpes, hepatitis B, pelvic inflammatory disease, ectopic pregnancy, premature labor, HIV, and malignancies related to sexually transmitted diseases.

Adolescents often become involved in sexual activities to the neglect of studies, social skill development, and community activities. My six years of working with this population brought me face to face with the abject social isolation of these children. They had no friends, just a series of sexual partners. Other teens, trying to "belong", drifted into the business of sex for drugs increasing their medical needs.

In the face of all these risks, each adolescent needs a medical home to teach prevention, provide medical care, and to support appropriate development. A medical home must supply health instruction to the adolescent and their parents, Medical care for the acute illnesses and chronic problems, counseling, phone advice, and easy access twenty four hours a day. I believe this expertise is found not in a clinic, but in the pediatrician's office and feel that every adolescent requires this care. As they face the problems of our society, the adolescent must have the guidance which a pediatrician is trained and experienced to provide.

What benefit does this early sexual activity provide to the adolescent? I know of none. I have not had anyone tell me of any nor have I read articles even suggesting that early sexual activity is of any benefit to the adolescent. Yet, I have cried with the emotionally wounded, treated the sexually transmitted diseases,

hospitalized the pelvic inflammatory diseases, referred the infertility and cervical cancer. Girls who thought the young man who had sex with them loved them, have come to my office depressed and threaten suicide when he moved on. Just last Thursday, in the ER, I treated just such a case. A month ago, a 16 year old died of an overdose of propanol because his girl friend ended their sexual relationship. As an adult, the sexually active teenager often desires to conceive but cannot because of prior infections. In 1985, Clark from Toronto noted that cervical cancer is 3-4 times more prevalent in people with two to five sexual partners. Time, emotional pain, and physical disease are the cost of premature, promiscous sexual activity. True abstinence prevents all these problems our hundred percent of the time and alleviate much of the subclinical and subconscious anxiety which is the basis for of the adolescent behavioral problems we observe.

In a failed attempt to reduce teenage health problems, school based clinics have developed since the 1970's. The clinics fall short of the comprehensive requirements of the adolescent and create false security for many parents and teenagers. The school based clinics fragment the teen's health care because only 66% of the clinics are open as much as 40 hours a week. They do not provide night or weekend coverage and only slightly over half were open in the summer. The emergency rooms cannot reach the clinic's "health care provider" when their patients come for service. The patient has no one to call at night for questions. Duplication of medications and contradictory medical advice are often given by the different providers. Parents are not able to help in history giving or to help in administration of suggested therapy.

The cost for this fragmented partial care varies by location from 37 dollars per visit to 81 dollars per visit. In comparison a pediatrician visit is 30 dollars and is comprehensive in nature. School based clinics may limit the freedom of the teen and their family to choose the physician who they feel would best meet their needs. Our tax dollars could be more effectively invested in allowing the families to select a more cost effective, comprehensive pediatric office.

In 1987, the American Academy of Pediatrics published a cautious statement regarding school based clinics. The AAP asked for more research to be undertaken. Only eight of the subsequent studies in peer review journals used required pre and post statistics in their studies. None of these studies proved that the clinics meet their goals. In Gary, Indiana, the study found no difference between SBC and control schools in birth rates. After reviewing Medline and Psychologic Abstracts searches on school sex education, Stout concluded in Pediatrics in 1989, "Our findings indicate that the expectations of altered adolescent sexual activity, contraceptive behavior, and pregnancy are unlikely to be fulfilled by these programs..." In 1982, the Council on Scientific Affairs of the AMA examined SBC's and stated, "Data are not sufficient to support the universal establishment of school based health programs." The American Academy of Pediatric's Survey of

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March 1988 revealed only one third of pediatricians supported school based clinics.

To reduce the incidence of sexually transmitted diseases and pregnancy, the condom has been suggested. Condoms must be utilized during all intercourse, semen must not be allowed to leak over the condom, and the condom must be intact. Dr. Thomas Elkins, Chief of Gynecology at the University of Michigan noted that 5 - 30% of non latex condoms leaked water molecules which are larger than the herpes, HIV, and wart viruses. Latex can cause severe allergic reactions, and Consumer Reports states that condoms have a 15-35% failure rate in preventing pregnancy. Abstinence will ensure no transmission, and the promotion of intercourse within marriage will create healthy role models. In Planned Parenthood, the Family Planning Perspectives 1990, Howard and McCabe showed that students in an abstinence-based program are five times less likely to engage in intercourse than a control group.

Our adolescents face increasing health challenges which require comprehensive medical care. We need to assure them access to health care providers who can meet those needs and furnish current medical and counseling information to aid them in their development to adulthood. This kind of care can be found in a pediatrician's office. It cannot be found in a school based clinic. Our success should not be measured by the increase in sales of latex condoms, but rather in the increased numbers of abstinent youth, healthy and fully engaged in the real joys of adolescent experiences.

Chairwoman SCHROEDER. Thank you very very much.

I am going to yield to my distinguished colleague, Congressman Johnson, for questions.

First of all, he has been in here admiring the art in this room, and we picked this room on purpose because this is all paid for with taxpayer money. I knew you would be thrilled.

But DOD has this wonderful art in the Pentagon program. It is very moving, and when people talk about how there is no waste in the Federal Government I always think that this is a good room to have meetings in. It may be art, but I have yet to see it.

So I think he hit the nail right on the head. He immediately sent me a note saying "I think I know why you picked this room."

Anyway, the floor is yours, Congressman.

Mr. JOHNSON. Thank you.

One of the things that I am struggling with as I listen to this very positive discussion from the panelists here today is what we ought to be doing. There are some disagreements, but all of them come down to recommendations that I suspect would involve a much greater financial commitment than, frankly, we are going to see. You know it, and I know it; And it isn't necessarily the way it ought to be. In fact, it isn't the way it ought to be, but it is a great reality.

And so we have panelists, some suggesting that, I believe, that virtually every at-risk teenager ought to be in some comprehensive program involving at least 15 different sessions with recommendations, perhaps, of demonstration projects starting out. But, obviously, you would have to go far beyond demonstration projects. They don't do a great deal other than to help us understand things a little better. And they don't actually deliver the services to the great numbers of people who need those services.

On the other hand, we have Dr. Meloy suggesting that none of those work anyway, and that every at-risk teenager ought to have comprehensive care from a pediatrician, which all of us would like to see, but, frankly, the likelihood of that occurring also seems to me to be very unlikely, given, if nothing else, the financial challenge that we face.

Let me ask Dr. Meloy—I would agree with you that abstinence is clearly the best alternative for everyone. But from a perspective of dealing with these young people who have enormous problems, psychological, psychiatric, as well as physical, do you have any recommendations—if we closed down the school based clinics, what delivery mechanism is there to provide alternative services and health care to these people? I guess I am grasping for how do you provide comprehensive health care, given the fact that we have a very patchy system of school-based clinics that is not as broad spread as perhaps we need it to be.

Dr. MELOY. I think we have some programs already in place, when we look at it from a pediatrician's point of view. We are immunizing the children prior to school. We have public health clinics to take care of the children from ages birth until five. I think that is a great platform to begin with, to begin our teaching there, to talk to the children as we talk about healthy habits. To use that firm basis that you already have in place through public health and through pediatricians' offices. To build from their education, as

the patients and these prospective teenagers have a place where they have come to trust, because they have had their ear infections, and they have had their various diseases treated. It is a perfect thought forum in which to continue that medical education as the child grows.

But many of the children, once they become five, no longer have access to those type of clinics. So you have primary school as a time period that many children fall out of ongoing yearly checkups with a pediatrician, a family physician or a health care provider. They fall out because the clinics are funded until age five. I think that time period, if continued care is done, continued teaching about good health habits as far as eating, as far as sexual activity, as far as danger seeking activity, that that is in place. We just need to extend it to carry that gap, because many of those children are being cared for hit or miss through emergency rooms. They don't have a pediatric home that they can go to when they have a question.

I think we need to continue that development and not leave that gap until they reach teenagehood. I think that that age group needs to be spotlighted, and education needs to continue to be put there.

But in the context of meeting their medical needs, because when people are ill, they do come to a physician, but the emergency room is not set up to teach about the other aspects of the child's life, and many times that is just so sorely needed, and we need a place where we can provide for that illness at that time but also educate at that same time.

Mr. JOHNSON. Dr. Rotheram-Borus, how do you see that, if all of these at-risk people are going to have the kind of comprehensive care that you recommend, do you really see any great likelihood that a mechanism can be developed that would actually accomplish that? Are we still talking about select groups here and there and demonstration projects in one community or another? How do we go about doing this?

Dr. ROTHERAM-BORUS. Actually, I think some of the programs that the CDC is developing are some very positive models. Often Federal funding is given in kind of a competitive way that enhances competition between agencies. In the last few years the CDC has been putting together a model where, in fact, the incentives are given for collaboration across agencies.

I don't think—that you are not going to have the money to fund new agencies or totally new programs. The kind of model that we used was a partnership between researchers and staff in the shelters.

Far more important than new staff was to train the cooks, the social workers, the janitors—whoever has contact with youth—in a model so that there was a preventive environment. So that on the local level, on an institutional level, it is who you train and make it part of the institution, part of the school-based training that would go from K to 12.

But then across agencies—the incentives need to be given for agencies to work together so that, as I started to say, the CDC funded public health departments, to collaborate with hospitals in a new and different way, to then collaborate with community-based

networks—community-based agencies. And when incentives are given for that collaboration and interagency network, rather than for one agency mounting a program, great benefits occur. And I think when the funding starts going that way that you can begin to see comprehensive care in a realistic manner.

Mr. JOHNSON. Thank you. I know that all the Members of this committee share a very intense level of frustration knowing that our financial resources are not what we would like to see them or what ought to be, in my view, such a high priority. We know that we are saddled with some very difficult priority-making decisions here, relative to where we use the limited dollars we have.

Are we going to use more dollars in this area? If we do, it means less dollars for child care, for Head Start, preschool inoculations, for enhancement of school programs, for nutrition programs. These are all—these are all tradeoffs to some degree or another, tradeoffs that we don't like to make, but which we are confronted with as of right now.

But nonetheless, we need to expand the pie that is available for children, for families, for youth and we also need to be evaluating with your assistance mechanisms to make better use of the dollars we have so that we use them in ways that do, in fact, have a real live consequence for these young people, and I appreciate your testimony here today. I think it does contribute to that very much-needed dialogue.

I yield back to the Chairman.

Chairwoman SCHROEDER. Thank you very, very much.

Dr. Rotheram-Borus, another study I had heard about that was very disconcerting was that occasionally when young people of the college age were tested HIV positive, often their first instinct was to see how many more people they could infect. It was a real anger. Have you seen any of those?

Dr. ROTHERAM-BORUS. I have not seen those data. I know that recently in New Orleans Judith Rabkin and Robert Remien presented data indicating that persons infected with AIDS, three years later, are still very angry.

In our own study, we asked what would you do if you came up HIV positive? And we found that a substantial portion of youth said they would take everybody they could with them. There is a real gap, however between what youth say they will do and what they actually do. I think I would be concerned that these data are further used to stereotype youth.

Chairwoman SCHROEDER. Sure.

Dr. ROTHERAM-BORUS. Because I think there is a real gap between what they say they are going to do and what they are going to do. We find that in every area of adolescence. And I think that it calls for the need of some prospective studies of youths' responses to HIV testing.

Again, I am not advocating for the CDC, but they just recently put a call for proposals for such studies—I think came out in May—so that such studies are being initiated. But we have no data on that so far.

Chairwoman SCHROEDER. Dr. Gardner, I have many members of my family who are doctors in rural areas of middle America, and they are now saying for the first time they are seeing all sorts of

AIDS patients in their hospitals, that young people left these small towns and got AIDS and are coming home to die. And they are very concerned that rural America thinks that they are immune from this and the hospitals are not making adequate preparations.

I think you were kind of mentioning that nobody is really exempt, and that is the——

Mr. GARDNER. Absolutely. This is a tremendously mobile society now. People are constantly circulating in and out of the cities, and there are high levels of sexually transmitted diseases in various rural places. And these things provide heightened risk for HIV infections.

I think that the point you just raised has got to be considered when you try to think about the dollars that it is going to cost, if I could sort of turn the question a little bit to address Representative Johnson's point.

For me, the most vivid example would be some gay kids in San Francisco that have been studied recently. Researchers at the Center for AIDS Prevention Studies in San Francisco studied a small sample of gay kids found in places where young gay males tend to congregate. They found in the 17- to 19-year-old group that 43 percent of those kids reported an unprotected act of anal intercourse in the last 60 days. Again, there is an issue of stereotyping: this is a small group, as Dr. Ratheram-Borus pointed out. In that sample there was 12 percent HIV seroprevalence, so this is a group that has a high likelihood of producing many AIDS cases in the next few years. The cost of an AIDS case is astronomical. It does not save money to neglect the needs of those kids and not to give them individualized attention.

I am sure you grasp that, but I don't think that is widely understood that there are concentrated groups who engage in high levels of risky activity and are likely to produce many infections at an enormous cost.

Chairwoman SCHROEDER. Good point.

Dr. Meloy, I want to make sure, I think I understood it, but I want to make sure everybody understands. I think everybody would agree abstinence is obviously the best protection. But you are certainly not saying that because condoms could cause allergic reactions, because kids don't abstain, they shouldn't use condoms?

Dr. MELOY. That is not what I am saying at all. But I think it is important that something that is being handed out as frequently through our health departments and programs like this, that people understand the risk even of that. And I think that is an important——

Chairwoman SCHROEDER. That it is not risk free.

Dr. MELOY. That nothing is risk free in this world. There is a responsibility with all our actions, and when we are talking to people we want to talk to them about the ideal.

I think it is important that we get the ideal across. When we settle for second best, that we make sure people understand what second best is.

Chairwoman SCHROEDER. Absolutely. No, I have no problem with that. I want to make sure people didn't hear it, that—the other way.

Secondly, I guess I think that your points are excellent—it would be nice if kids had this relationship with pediatricians, but I know Children's Hospital in Denver found that across all income levels, there is a certain age when children wouldn't go to pediatricians anymore, they were too cool. And they were the ones leading the school-based health clinics and found it was picking up all sorts of people in all income categories, that they had really just fallen outside of the health care area.

So I wish you would take a survey. They have worked very hard on this and found that you just didn't get these kids. You have to do a whole new—maybe you need to have pediatricians that only deal with adolescents, but they don't go to see the baby doctor.

There is a real stigma among adolescents to go to a baby doctor to talk about your new grown-up problems. Maybe you don't see that in Virginia, but we certainly see that in Colorado.

Dr. MELOY. You are talking about the stereotype of the pediatrician.

Chairwoman SCHROEDER. But the kids have it.

Dr. MELOY. Some of the kids have it. All the programs in the United States now have a certain portion of pediatric training that is in adolescent medicine. We have a separate portion of the American Academy of Pediatrics that deals with adolescents, looks into their problems, and it is a developmental issue. Adolescence is a developmental stage, just like the stages we take the other children through.

More and more pediatricians are continuing to take care of their adolescents in their offices. The offices have changed and are continuing to change, as you will notice a lot in the decor. I think that is an important thing, to have someone who is trained in pediatrics, and the boards for adolescent medicine are making that training even more specific, so the pediatrician has spent that time with adolescents. They are a very enjoyable population to work with.

Chairwoman SCHROEDER. Some are. I am not sure that they all are. But I guess I would just say in the interim, there are many communities where I have seen the only way you pick up those kids is the school-based clinic.

Maybe as we catch up on this it is different, but we are seeing fewer and fewer pediatricians willing to take Medicaid patients. We see pediatricians being busier and busier. I think someone told me, I don't know if it is true, that they have the lowest incidence of suicide because they are too busy to contemplate it. Their being able to sit down and confer with kids makes it very hard to do.

They are also lesser paid among medical professionals because they don't deal so much with high tech, they deal with human beings. And unfortunately, I think they have their rate scale upside down.

But this committee has done a lot of work with the American Academy of Pediatrics. We have got a lot to do before we really deal with all the stereotypes, all the issues, and everything out there, and in the interim, one of the biggest problems I think we have had with school-based clinics is that they haven't—communities want to put restrictions on what they can talk about rather than allow them to be a resource for the kids. And I think that you

would agree that the school-based clinics should not have restrictions, they shouldn't have gag rules on them.

Dr. MELOY. I think as long as they are providing restricted care, I don't know that restrictions are bad for them. They are not providing 24-hour-a-day care. They are leaving that to emergency rooms that are much more costly, for adolescents and children with weekend coverage.

I think if a rapport has been built up with the child, the pediatrician can still take that counseling time. It is one of the things—we are so poorly paid because a lot of our visits take a lot longer. Because it takes a long time to talk to a teenager—when you have just told them they have gonorrhea and you have to spend a lot of time listening to them, talking about what the implications are within their family.

So you are right that we are low paid, because we have to take that time. The stereotyping is that there are a lot of young pediatricians coming out of programs that would love to take care of those adolescents, and a lot of the problem is reimbursement. Where you are saying it is hard for these children to find care. I think it is something that seriously needs to be looked into. Someone who has gone through an adolescent fellowship and training is inaccessible to the child because of finances.

I think that is an issue we really need to look to because a lot of these teenagers don't have access to any kind of coverage to help them get the care that they need.

Chairwoman SCHROEDER. I think that is true, but I think we put the trained pediatricians in the school-based clinics in Denver. You can work a lot of those things out. And having used pediatricians when my kids were little, I can't ever remember—nothing ever happened before the office closed. It was always at night, and the first thing was, take them to the emergency ward.

We ought to work towards those kinds of things. The school-based clinics tend to be one place where it is a good comfort zone, because at least it is accessible. But we will keep looking at it. And I wish you would look at the Children's Hospital in Denver.

Dr. Kolbe, you said the survey data allowed you to determine whether risky behaviors are correlated. Are they?

Dr. KOLBE. We have data from other studies that suggest that they are. We currently are in the process of analyzing data from the Youth Risk Behavior Surveillance System to understand the extent to which various risk behaviors are associated.

Chairwoman SCHROEDER. So you are looking at that and we may be able to get more precise information?

Dr. KOLBE. That is one of the reasons we developed that surveillance system the way we did. As I indicated in my testimony, we would be able, for example, to assess the extent to which kids who engage in sexual behaviors (that result in HIV infection and STDs and unintended pregnancy) also engage in alcohol and drug use, risky driving behaviors, and in violence.

Chairwoman SCHROEDER. So if we can find the correlation among these different risky behaviors when you finish all of this, then that ought to really help us in designing prevention programs, wouldn't you say?

Dr. KOLBE. We think so. As I indicated in my testimony and perhaps in some response to Congressman Johnson's question about the budgetary implications of prevention programs, we suspect that the most efficient way of reducing many of these risk behaviors is not through a haphazard one-week course in the 12th grade on HIV prevention, and a three-day course in the 10th grade on drug abuse prevention, and a two-day course in the 9th grade on drinking and driving.

We think that what our society has come to understand in the past several decades about health ought to be given to our children in a very systematic, complete way, as part of their education, beginning in kindergarten and continuing all the way through the 12th grade.

Chairwoman SCHROEDER. I think that is very, very important, and comprehensive. We have a lot more questions, and I don't want to take too much more time, so what I will do is announce to everybody now, the record is going to be open for two weeks, so if you think of more things you want to add or people want to submit things, I would be more than happy to do it.

Let me yield now to Congressman Riggs.

Mr. RIGGS. Thank you, Madam Chair.

Good morning. I apologize for being a little late. I was in the hopes of bringing my older son to hear this testimony, who is 16, but he was more interested in working in the office and sort of acting as my personal page for the month of June. Because I have a real family connection, you might say, to the subject matter, I am very interested to hear the testimony presented by our witnesses this morning.

I recollect back to my days as a member and school board president in my home community for five years, and we had a so-called family life or family planning course. It was a standard part of the curriculum offered in the 7th grade. And I was interested in hearing Mr. Kolbe's testimony about the importance of educating our young people beginning in, I guess, the earliest school grade and continuing on through their educational career, their secondary years.

Have you done any surveys to know how many public school districts in America offer some sort of educational and preventive programs with respect to this whole subject area?

In other words, let me just phrase that a slightly different way. How many school districts acknowledge the importance of imparting at least basic information to students and what grade span does that educational program cover?

Dr. KOLBE. We do have data about the extent to which the nation's 100,000 schools, are providing education about HIV prevention at various grade levels. About 66 percent of the nation's school districts require HIV education, as of the last survey.

Mr. RIGGS. May I interrupt for just a moment, Doctor? Is this part of a broader curriculum?

Dr. KOLBE. No, not necessarily.

Mr. RIGGS. So it is only focused on HIV causal behavior?

Dr. KOLBE. We don't know how many school districts support sex education, nor do we know precisely how many school districts rec-

ommend or support a more comprehensive school education program.

Mr. RIGGS. I thought one of the interesting things about our experience, Dr. Meloy, not only as a school board member but as a parent, was that when this course was offered in the 7th grade to my older son, parents were required to attend an orientation of sorts, an overview seminar, if you will, before the course was offered in the school. As I recall, it was offered in the latter part of the school years, shall we say, the second semester of the second grade.

How important is it in terms of perhaps preventing adolescent at-risk behavior to involve the parents or the family unit as a whole?

Dr. MELOY. I think it is of paramount importance, because the parents are the role models that the children see day in and day out. I think any cooperation that we have in the team between the schools, the parents, and the adolescents is wonderful because it supports the same message at home. Because as we were saying, it is not just a one-shot deal. It is something that needs to be reinforced at various times.

Adolescents and teenagers all have periods which are critical learning periods. The school has part of that time period, while a teenager is at school. The parent has another part of that. I think we need to work together as a team so when the child is ready to learn, in whatever location they may find themselves in, with their parents, with their teachers, with their pediatricians, that that information can be given because we want to help this child's total development.

I think it takes total involvement—the home, the school, and the medical profession—to work together towards helping the children make healthy choices.

Mr. RIGGS. So you include the pediatrician as part of that team, if you will, and there has to be a compact, if you will, between the youth, parents, and the pediatrician?

Dr. MELOY. I think that is very helpful. I have helped various schools with the courses they have needed, helped with the drafting and doing some of the on-site teaching work. Questions and answer time is basically what I have done, and a lot of the pediatricians in our community serve the school boards in that way, to help support the teachers with information, resource information, and to go to the school to answer any of the questions the teens may have.

Mr. RIGGS. One of the things I was struck by when we went through this as a family was how clinical the approach was to imparting the information, both to youths and the—the 7th grade youths participating in the program, as well as the program.

That is to say, the information was of a very technical and medical nature. It didn't talk at all about the development of values or how it might relate to the standardly accepted morals of our society.

I was very, very struck by that, and wondered if in part that was because of the leeriness on the part of school officials to cross that line or perhaps, you know, it would blur the church-state separation, if you will.

Is there a way, or is there a role in your mind to include values training as part of an overall larger curriculum that also deals with family planning and all these various at risk, very sexual practices that might put a significant segment of our adolescents at risk?

Mr. GARDNER. Can I address that, Congressman?

In a book a number of us put together on this topic last year, one of the chapters was on precisely this point. A colleague of mine, Dr. Catherine Lewis, reviewed a number of comprehensive school-based programs where values training was an essential piece of what was going on. These were nonjudgmental values. These were values that did not try to isolate certain people as wrong or needing to be stigmatized or isolated. These were values that stressed the importance of consideration for other people and the importance of consideration for one's own health.

I strongly believe that we should implement values-based training on those principles from an early age. As Dr. Kolbe said, it is essential to have things start at the beginning of the educational process and continue all the way through. The values should incorporate a responsible care for the school community, that is, training kids to care about the environment that they are in, and to care about how well everyone is doing in that environment. You can find really impressive results, really glowing schools that do do a good job. You can't prevent risk taking completely in adolescents, but I think there is promising evidence that you can accomplish important things.

But I want to stress that you can't use values to isolate people. Because if you do that, you will put them in a position where they can't approach a pediatrician, where they can't make those contacts with adults that they need in order to get the kinds of things that Dr. Meloy is talking about. If a kid is afraid to talk about who they are sexually with their parents or with other members of the community, then you have left them on their own, and they are going to have to make these choices entirely for themselves, and I think we all agree that they are not going to be able to do it as well as they could in the context of supportive help from adults.

Mr. RIGGS. Thank you, Dr. Gardner.

I had one other thing to add, particularly for my two distinguished colleagues on the panel. I was home a couple of weeks ago actually driving up to the northern part of my district. I was listening to my local radio broadcast, and I caught the newscast talking about a raging controversy in a K–12 school district, and the controversy there had ensued between a very vocal parent group and the school board on whether or not to allow condoms to be dispensed at a prom. When I heard the word "prom," I immediately thought, well, certainly senior prom. I just about ran off the road when I heard they were talking about sophomore class prom.

I did a little research and what is most disturbing about this incident is that there isn't a comprehensive curriculum, comprehensive course as part of the standard curriculum offering in that school district which would also include values training and information as part of that education, prevention.

When I say "values training," I am not talking about necessarily any kind of life-style judgments. But I am talking about promoting

abstinence as a viable choice. I am talking about promoting the idea of respecting and caring for your sexual partner and being very selective about that sort of behavior.

I don't think you can have the one—I think it sends a very confused message to our young people to hear adults debating whether or not to allow condoms to be dispensed at sophomore class prom without the sufficient groundwork being laid in advance to inform our young people about their other choices and their ability, and I think we have—all of us have a concomitant responsibility, hopefully as responsible adults, to impart to our young people training or methods on how to deal with the very issue of resisting peer pressure and the ability to be able to say "no" under the toughest circumstances, sometimes when you see other at-risk behavior, which contributes to sexually at-risk behavior, drug use or rampant alcohol use, which we are told is—maybe we will hear something about it over the next two days—more and more prevalent among our young people.

I want to relate that Wall Street key study, if you will, from home, and the fact that I think this is a terribly important subject and one where we have a lot more work to do in terms of truly preparing our young people to take their place in society as mature, responsible adults.

Chairman SCHROEDER. Thank you.

Congressman Wolf.

Mr. WOLF. Thank you. I am sorry I was not here. I was a speaker at a naturalization ceremony in my district. I could not be here.

I do not have any questions as I didn't read your statements, and therefore that would not be appropriate. But perhaps I will submit several for the record.

Dr. Gardner, how many children do you have?

Mr. GARDNER. I have two.

Mr. WOLF. I have five.

You said nonjudgmental values. What are nonjudgmental values?

You really ought to explain that nonjudgmental values equals no values.

Mr. GARDNER. That is an interesting point. I am sure that I was——

Mr. WOLF. Do you believe there are some things that are right and some things that are wrong? Are there not some things that are eternally right and eternally wrong?

Mr. GARDNER. That is actually my personal view.

Mr. WOLF. If you believe that, then ought you not say that? I mean, what kind of message are you sending? I just spoke to a graduating class—If I just got up and said to these people, as you go out in life, there are nonjudgmental values, they would ask what do you believe in?

Mr. GARDNER. Let me——

Mr. WOLF. You really have to clarify that.

Mr. GARDNER. Yes. Thank you. What I wanted to say is that there are young people who have identified themselves as homosexuals, for example. I do not think it is helpful for them to be told that there is something wrong or evil or to be regretted about that choice.

I had in mind a particular set of judgments that I hear frequently made in these contexts. I certainly agree with you entirely that the notion of nonjudgmental values in general is ridiculous. Of course, values involve judgments. I tried in my comment to make clear the kind of judgments that are important.

The kind of judgments I think that are counterproductive are labeling particular life styles as deviant or not discussable. That is really what I meant, sir. And it is clear to me that I should be more straightforward and clear that that is exactly what I meant.

Mr. WOLF. Well, I won't have a lot of questions, because again, as I say, I don't know what you have all said, so that would not be appropriate. I will have some questions for the record.

Let me just say that I believe there are things that are right and I believe there are things that are wrong. I believe with young people, you clearly have to state what you believe is right and what you believe is wrong. If you are wishy-washy, you provide no standards that people can go by.

If I were in this community that Congressman Riggs were in and somebody were to ask, is it appropriate to dispense condoms at the senior prom, not to mention the sophomore prom, I would say it is wrong.

Would you agree that it is wrong?

Mr. GARDNER. No, I would not at all agree with that.

Mr. WOLF. Well, then, I can see we don't have a lot in common.

Do you agree it is wrong to distribute condoms at the senior prom, Dr. Kolbe? Let's take the senior and the sophomore prom. At the sophomore prom, would you, and at the senior prom, would you?

Dr. KOLBE. I think Mr. Riggs put his finger on it. The more important thing to do is to provide education.

Mr. WOLF. Exactly. But don't you think it would send the wrong message to distribute condoms at the sophomore and the senior prom?

Dr. KOLBE. I think we consistently need to tell our young people very clearly, those in high school, that there are numerous public health reasons why they should not engage in sexual intercourse.

Mr. WOLF. And other reasons, too. As a parent, if I knew that kids of mine were going to a prom where people in responsible leadership positions were going to distribute condoms for example.

Dr. Kolbe, I assume you do not believe it is appropriate.

I am not going to go down the panel. I want to go back to Dr. Gardner, but he apparently thinks it is okay. Reasonable men and women would disagree on issues, but there are certain things where you have to say this is right and this is wrong. Clearly, something like condoms at the senior class prom as well as the sophomore class prom would be wrong.

Again, thank you very much for taking the time.

If the Chair permits, we will just submit questions for the record.

Again, I do apologize for not being here.

Chairwoman SCHROEDER. Let me thank the distinguished panel and we appreciate that, and announce again that the record will be open for two weeks.

Let me call the second panel up to the table this morning.

First, we have Lenore Zedosky, who is the Assistant Director of the office of Educational Support Services in the West Virginia Department of Education, in Charleston, accompanied by Rae Ellen McKee, the National Teacher of the Year, from Pointe, West Virginia; Dorothy Wodraska, who is the Assistant Director of Project I-STAR in Indianapolis, Indiana; Jose Duran, the Executive Director of HOPE in Boston, Massachusetts; and Kathleen Sullivan, who is the Director of Project Respect in Illinois.

We are very, very happy to have all of you here with us this morning, and the rules are the same. We will put your testimony in the record, and then you may summarize however you may like.

Let's start with you, Lenore.

STATEMENT OF LENORE ZEDOSKY, ASSISTANT DIRECTOR, OFFICE OF EDUCATIONAL SUPPORT SERVICES, WEST VIRGINIA DEPARTMENT OF EDUCATION, CHARLESTON, WV

Ms. ZEDOSKY. Thank you for this opportunity to present testimony regarding comprehensive school health initiatives that are making a difference for children in West Virginia.

I am here today representing the West Virginia Department of Education and the West Virginia School Health Committee which has been appointed by Governor Caperton to be a catalyst in moving us forward in an initiative that will make a significant difference in the health status of our children and eventually of our entire population.

West Virginia statistics about child well-being are alarming. One in two babies is born into poverty; one in six babies is born to a teen mother. Children die from causes that are preventable: accidents, homicides, suicides, and low birthweight. Forty-seven of the 55 counties in West Virginia are designated as medically underserved areas. Mortality rates are 19 percent higher than the national average.

In the spring of 1990 the Department of Education conducted a youth risk behavior survey among our ninth through twelfth grade students that gave us even more alarming data. Our students are engaging in multiple risk behaviors such as riding in automobiles with individuals who have been drinking, drinking and driving themselves, and engaging in unprotected sexual activity. Twenty-three percent reported they already had had as many as four sex partners. All of our children are at risk.

West Virginia is taking the lead in addressing the health problems of its citizens by initiating solid proactive steps to do something about escalating health care costs which last year totaled more than the entire State budget.

In the summer of 1990, Governor Gaston Caperton appointed a 25-member school health task force comprised of leaders in business, education, government, health care, and the community. This task force studied issues surrounding school health and published a precedent-setting report that shows a commitment to change that is unique in this country.

In 1990, the West Virginia legislature created a cabinet on children and families which is chaired by Governor Caperton and brings together State agency leaders to oversee delivery of compre-

hensive services to children and families including the elimination of barriers that prevent access to these services. Business, government, education and the public are committed to our initiative.

Mr. C.E. Compton, a businessman in West Virginia, cares about his fellow citizens. For over 25 years he has envisioned a healthy State through the development of school programs which teach children to be healthy. This individual funded a successful model program in Harrison County schools that reaches 3000 students and has received numerous State and national awards.

He encouraged the Governor to appoint the task force on school health and has met with various political leaders over the last 25 years trying to implant the vision for a healthier citizenry via development of health programs in school settings.

Maybe if I paint you a picture of how a school that has a comprehensive health program in place would look for a student, you will have a better understanding of our vision for West Virginia.

As Johnny and Mary arrive at school for the first day to begin kindergarten they will already have had complete health appraisals and physical fitness examinations. Information related to their health status will have been shared with the school by the community health provider and their Head Start or preschool program.

If the child has a health problem, the school nurse will have written an educationally-relevant health care plan. Within the classroom, they will be learning to read, write and do other basic skills. In addition, they will have a health education program. The basics will reinforce what they are learning in health.

For example, as they are learning computer skills, they enter their own health data: height, weight, perhaps what they had for lunch, to determine if their nutritional needs have been met. The school cafeteria serves lunches that meet the dietary guidelines for the Nation.

As they move through their school years, a counselor and a school nurse will periodically assess John's and Mary's needs. They participate in student assistance programs as well as peer helping programs which are an integral part of the school program. The school environment is physically safe and socially and emotionally nurturing.

The physical education program is an integral part of the educational day as children learn and practice lifetime fitness activities. Students will be competing with themselves to improve their own physical fitness and health status.

Report cards relate fitness status and provide a prescription for improvement. Teachers participate in wellness programs. The school building belongs to the community and houses aerobic classes, cooking demonstrations and health centers.

Comprehensive health teaches children about the importance of their own health, the meaning of self image, the development of good self-esteem and self-efficacy and how good decisions can be made which will better equip them to deal with peer pressures and the conflicting messages they receive from a changing society. School health programs help children set goals for themselves as an integral part of the effort to improve education outcomes for every child.

One area of particular emphasis in the adolescent health education program is to empower youth by teaching them the skills needed to live effectively with each other in the world. Children find the relationships and influences of their peers so much more significant as they move into adolescence. It is very difficult to say no to friends, especially a best friend and boyfriend or girlfriend. Young children are not taught how to say no; they are not even given permission to say no. Our programs emphasize skill building in this area.

As students become more responsible for their own health and well-being, they must have access to health services that complement the health education program. Health centers will be located in schools to provide cost-effective, comprehensive services for students of all ages.

I want to emphasize the importance of the program beginning at the community level. To be effective, wellness and disease prevention programs must be conducted in partnership with parents and the community.

Communities must design their own programs based on strengths and priorities for their students. The community's economic development will be enhanced by school-community business partnerships. School programs will be closely integrated with the existing service structure and social organization of the community.

Such school-community collaboration has several benefits. It enhances opportunities for information exchange and social support among school and community members. It facilitates community ownership of both the comprehensive school health program and the community-based health promotion program. It allows for health problems to be addressed within the context in which they exist. It provides a forum for the institutionalization of disease prevention and health promotion initiatives within a community and thus within its schools.

West Virginia has received valuable technical assistance from federal agencies, primarily the Centers for Disease Control which assisted us in finding fiscal resources as well as helping us learn about the most effective programs based on research and evaluation.

In addition, we have been fortunate enough to receive grants from the U.S. Department of Education, the Council of Chief State School Officers and the National Health/Education Consortium, and we have had technical assistance and funding directed to us by becoming a "Code Blue" State as designated by the National Association of State Boards of Education and the American Medical Association.

Assessment and evaluation of our comprehensive school health initiative will be extensive. All areas of the project will be evaluated including teacher training, student outcomes, health and physical fitness indicators and behaviors, teacher wellness indicators, successful policy implementation, utilization of health centers, parent perceptions, and community involvement.

The years ahead present our State with a rare combination of challenges and opportunities. There are powerful solutions to the problems at hand. Communities, businesses and individuals will all benefit from these collaborative efforts. Healthy young people will

become better educated, more productive and be far less likely to need premature, costly health and social services.

We have charted the course for a healthier future in West Virginia. This course will not be easy. Solutions to the health problems facing our young people today will require the combined commitment, time and energies of government, schools, businesses and individuals. Yet, meeting these challenges and overcoming them is the only sound means to ensure a brighter, healthier future for our State and our Nation.

Madam Chairwoman, I have some written testimony I would also like to submit, including a letter from Governor Gaston Caperton, reinforcing the importance of our endeavor in West Virginia.

Chairwoman SCHROEDER. Without objection, we thank you very much and we move to our next witness.

[Prepared statement of Leonore Zedosky follows:]

PREPARED STATEMENT OF LENORE ZEDOSKY, ASSISTANT DIRECTOR, OFFICE OF EDUCATIONAL SUPPORT SERVICES, WEST VIRGINIA DEPARTMENT OF EDUCATION, CHARLESTON, WV

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In the spring of 1990 the Department of Education conducted a Youth Risk Behavior Survey among our 9th through 12th grade students that gave us even more alarming data. Our students are engaging in multiple risk behaviors such as riding in automobiles with individuals who have been drinking, drinking and driving themselves, and engaging in unprotected sexual activity; 23% reported they already had had as many as four sex partners. All of our children are at risk.

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Such school-community collaboration has several benefits:

- It enhances opportunities for information exchange and social support among school and community members.
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Assessment and evaluation of our comprehensive school health initiative will be extensive. All areas of the project will be evaluated including teacher training, student outcomes, health and physical fitness indicators and behaviors, teacher wellness indicators, successful policy implementation, utilization of health centers, dietary habits, parent perceptions, and community involvement.

To our knowledge, no other state has taken on such an extensive school health project on a statewide basis. West Virginia has a need, a plan and the commitment of individuals at all levels. Now we need to reallocate current funding, seek new dollars and continue to receive technical and fiscal support from the Federal government.

The years ahead present our state with a rare combination of challenges and opportunities. There are powerful solutions to the problems at hand. Communities, businesses and individuals will all benefit from these collaborative efforts. Healthy young people will become better educated, more productive and be far less likely to need premature, costly health and social services.

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Chairwoman SCHROEDER. We are very, very happy to have the Teacher of the Year. So the floor is yours.

STATEMENT OF RAE ELLEN McKEE, 1991 NATIONAL TEACHER OF THE YEAR, POINTE, WV

Ms. MCKEE. It is my honor to be here. It is such an honor to be invited to speak to you this morning.

As representative of the Nation's classroom teachers and as a mother of two small children, I have a particular interest in the future of our children in States like my own West Virginia, and how these children's lives can be impacted by comprehensive programs delivered in the school setting.

As a remedial reading teacher in Slanesville, West Virginia, I work with children from rural and often poor socioeconomic backgrounds. Every day I most dramatically see the importance of the school as a nurturing agent of the whole child.

Because my school is small we cannot support a guidance counselor, staff nurse, or social worker. I and my colleagues work with children as though they were members of our own families.

I often encounter children whose lack of medical and dental attention has led to chronic inner ear infections or mouth abrasions that interfere with their ability to hear and to articulate words. I and other teachers at my school have often taken children ourselves for medical appointments, laundered their clothes, instructed them in personal hygiene habits, and sent them healthful afterschool snacks.

Very often the children I see in my remedial class are there because health has prevented them from succeeding in their classroom reading program. It, therefore, becomes my responsibility as a reading specialist to make sure that each child's health needs are being met before I can continue my reading instruction. Intervention such as this is seldom part of our definition of a successful literacy program.

Educators know that in order for a child to learn, he must be free from embarrassment, free from pain, and free from health problems that interfere with learning.

In our ever-changing society, a multitude of negative factors can profoundly affect a child's life. The education of the whole child cannot be solely the responsibility of the classroom teacher. A child's physiological, social, and mental growth must be nurtured through partnership of family, school, social service agencies, and the community at large.

Only when all of these powers work together will we see significant improvement in the health, well-being, and future of our students.

Chairwoman SCHROEDER. Thank you very much.

[Prepared statement of Rae Ellen McKee follows:]

PREPARED STATEMENT OF RAE ELLEN MCKEE, 1991 NATIONAL TEACHER OF THE YEAR, POINTE, WV

Madame Chairwoman, Members of the Committee. I am honored to have been invited to speak with you today as a representative of the nation's classroom teachers and as a mother of two children. I have a particular interest in the future of children in states like my own West Virginia and how these children's lives can be impacted by comprehensive programs delivered in the school setting.

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Only when all of these powers work together will we see significant improvement in the health, well-being, and future of our students.

Congresswoman SCHROEDER. And now we move along to Dorothy Wodraska. We really welcome you and thank you. The floor is yours.

STATEMENT OF DOROTHY WODRASKA, ASSISTANT DIRECTOR, PROJECT I-STAR, INCORPORATED, INDIANAPOLIS, IN

Ms. WODRASKA. Thank you, Madam Chairwoman, and distinguished Members of Congress.

I am here to share some good news with you. Substantive prevention programs that are likely to change drug abuse behavior must provide consistent no-use prevention messages because there is no such thing as responsible drug use for adolescents.

Project I-STAR taught awareness and was designed to create an environment that supports and encourages youth to remain drug free.

In order to accomplish those goals, Project I-STAR incorporates resistance skills, competence skills and environmental support strategies in working with youth, their parents and the community to counteract the many pressures to use alcohol and other drugs.

As a comprehensive community approach to drug prevention, Project I-STAR includes five areas of influence through their prevention programs, and messages are delivered on a continuing basis over several years. The multiple component approach features a student curriculum, parent program, community organization, media involvement and a research component.

The student curriculum targets students in the transitional year between elementary and middle junior high school. These students are at the greatest risk for experimentation and are most susceptible to peer pressure.

Early adolescence is the high-risk period most associated with the onset of use of tobacco, alcohol and other drugs. With respect to the framework of a two-year, action-oriented curriculum, students are taught to resist drug use pressure, to be assertive in selecting alternatives to drug use, to recognize and/or countermand peer, adult, and mass media modeling influences, and to change their perception of social norms relative to their approval of drug use.

Research indicates that changing social influences to using drugs changes or mediates drug use behavior, and the change in social norms is more effective than just changing individual resistance skills or providing information on social or physical consequences of drug use.

The I-STAR parent program activates parents in various strategies. The student curriculum involves parents in the student's I-STAR homework, thereby encouraging parent-child communication on drug issues.

The establishment of a school I-STAR parent committee supports initiatives. A unique dimension of our program provides parents training other parents in parenting skills, and community involvement to support youngsters in adopting or maintaining a drug free lifestyle.

A comprehensive community approach will require a partnership or coalition of community leaders to coordinate drug prevention

services and activities. Project I-STAR enlists community leaders and trains them in prevention strategies.

This council is organized into eight action committees to work within their respective organizations to support drug free youth in various activities. This grassroots approach in developing critical legislation has proven to be extremely effective in prevention programs.

Throughout the work of volunteers working with State and local governing agencies, changes in social policies are promoted to create an environment conducive to deterring youth from the use of alcohol or drugs.

Recognizing the tremendous influence of mass media in impacting the decisions of young people, Project I-STAR attempts to integrate the media into the comprehensive prevention effort to advocate drug free youth, developing a working relationship with the media, involving the media in community prevention efforts and assisting the media in communicating the no use message.

The media becomes a positive influence on young people promoting drug free youth in their news, programming, public service and their advertisements.

Any successful prevention program needs to know if its message is being heard and whether the program works to change drug use behavior. Project I-STAR asks these questions through its annual survey of parents, students and leaders. The research design includes random sample studies to monitor the prevalence of alcohol and drug use and the largest school-based longitudinal program in the Nation.

We survey 12,000 students annually. Project I-STAR's research design also includes annual surveys of several hundred community leaders to study their health habits and attitudes.

In addition to its own research, Project I-STAR is part of a larger study conducted by the researchers at USC and funded by a grant from the National Institute on Drug Abuse.

The Midwestern Prevention Project also includes Project STAR in Kansas City. Findings from both the programs show significant promise in reducing the use of alcohol and drugs among youth. The magnitude of prevention program effects range from 35 to 61 percent reductions in cigarette use; 20 to 31 percent reductions in alcohol use; and 20 to 53 percent reductions in marijuana use. These are calculated in comparing the difference in rates of increases in schools receiving the program and control schools.

In addition, the analysis of the data and a one-year follow up indicated that the parents reported their own drug prevention practices and personal involvement as extremely important in discussing prevention with their children, and even reports of exercising regularly were higher than control group parents.

Preliminary results from Project STAR in Kansas City prompted curricular and program changes, including the addition of three lessons focusing specifically on alcohol as a drug.

Other innovations resulting from effective efforts included accelerated implementation of community involvement in Indianapolis.

Training of personnel has been revised based on the results of the observational data, analysis, and participant evaluations as well.

Does the successful approach to prevention have applications for other types of risky behavior? My personal experience as an I-STAR classroom teacher and observer of more than 100 classroom sessions provides a unique perspective from which to comment.

I have witnessed first-hand the excitement and confidence of youngsters who come to understand the nature of pressures that exist to engage in risky behavior and their ability to resist those pressures.

This social-skills approach would seem to have great promise when coupled with a support system established through a comprehensive community prevention program. However, perceptions of normative expectations have such a substantial impact that a change in social norms must accompany resistance skills and knowledge of consequences in order to be effective in preventing or reducing any risky behavior.

Changing social influences to engage in risky behavior mediates the behavior. Therefore, any efforts to prevent such behavior must be comprehensive in approach, provide consistent messages from all social influences, including mass media, school, parents and home, community organizations, and local community policies related to the behavior and require evaluation to assess effectiveness of strategies employed.

Project I-STAR promotes the motto, drug free youth is everybody's business. Although our focus and mission is specific to one particularly risky behavior, the responsibility indicated in our motto seems appropriate for others as well.

The young people of our Nation need the best efforts of all to promote broad-based wellness and they certainly deserve no less than our very best.

I commend this committee for initiating this inquiry and I thank you for the opportunity to share the nationally recognized effective prevention model implemented by Project I-STAR.

Chairwoman SCHROEDER. Thank you very much.

It is nice to get good news.

[Prepared statement of Dorothy Wodraska follows:]

ABSTRACT

PREPARED STATEMENT OF DOROTHY WODRASKA, ASSISTANT DIRECTOR, PROJECT I-STAR INCORPORATED, INDIANAPOLIS, IN

Project I-STAR (***INDIANA STUDENTS TAUGHT AWARENESS AND RESISTANCE***) is a prevention program designed to reduce alcohol and other drug use among young people and to create an environment that supports and encourages youth to remain drug-free. To accomplish these goals, Project I-STAR incorporates resistance skills, competence skills, and environmental support strategies in working with youth, their parents, and the community to prevent the use of alcohol and other drugs among youth.

The comprehensive, community-wide program features multiple components: a student curriculum, a parent program, community organization, a research component, and media involvement.

The student curriculum targets students in the transitional year between elementary school and middle/junior high school, because this is a critical time for young people. According to prevention research, these students are at the greatest risk for experimentation and are most susceptible to peer pressure. Therefore, by targeting young people at this critical age, Project I-STAR hopes to delay the onset of alcohol and other drug use among youth and subsequently reduce the level of use among all young people.

Realising that parents are ordinarily the first and best teachers of their children, Project I-STAR assists parents in drug prevention through various strategies! A unique dimension of the I-STAR Parent Program involves parents training other parents in prevention strategies; parenting skills, and community involvement. These efforts serve to support youngsters in adapting and maintaining a drug-free lifestyle.

Prevention is a process, not a singular event. Studies indicate that comprehensive community programming provides the best opportunity for effective alcohol and drug use prevention and health promotion. Therefore, Project I-STAR also promotes social policy change to create an environment conducive to deterring youth from the use of alcohol and other drugs.

PHILOSOPHY

As a comprehensive, community-wide substance use prevention program, Project I-STAR draws extensively from social learning and attitudinal theories and adopts a social skills approach to drug use prevention. Epidemiological studies conducted by leaders in drug prevention research such as B.R. Flay, B. Forster, J.D. Hawkins, J.M. Moscowitz, M. Murray, M.A. Pentz, J.E. Rhodes, and T.W. Killen are the basis for the social approach adopted by Project I-STAR.

According to these studies, social influences to use alcohol and other drugs are major predictors of drug use onset in early adolescence. These include perceived pressure from peers, adults, and mass media to use drugs; peer and adult use of drugs; peer and adult sanction or approval of drug use; and availability and access to drug use situations. Also, the studies indicate that environmental influences such as smoking and drug policies and community norms for use may interact to affect the progression of drug use in adolescents.

Therefore, Project I-STAR embraces the philosophy that social influences are key factors in the use and misuse of alcohol and other drugs and teaching awareness and resistance skills to youth will equip them with the necessary tools to remain drug-free -- Indiana Students Taught Awareness and Resistance. In addition, to support the drug-free choice of young people, Project I-STAR creates a community environment that sends a consistent "no use" message to youth through ongoing coordinated community-wide strategies.

Within this framework, this social influence prevention program teaches youth

a) to resist drug use pressures,
b) to be assertive in selecting alternatives to drug use and drug use situations,
c) to recognize and/or countermand peer, adult, and mass media modeling influences, and
d) to change their perceptions of social norms and approval of drug use.

Project I-STAR utilizes a comprehensive approach to the prevention of alcohol and other drug use among youth in order to affect all the influences in a young person's life -- family, friends, school, community, and mass media.

The mission of Project I-STAR embodies the philosophy of Project I-STAR: to reduce the use of harmful substances among youth by teaching effective resistance skills and by fostering parent and community support.

In achieving this mission, Project I-STAR believes:

- Students can be influenced to live a drug-free life style.
- Preventive drug use education of young people is the key to a drug-free society.
- There are pressures brought to bear on young people which make them susceptible to harmful use of alcohol and other drugs.
- Action should be taken to counteract cultural concepts that present alcohol and other drugs as acceptable.
- Students need to be made aware of alcohol and other drugs' harmful effects and the potential for their abuse.
- The total community must be involved in the efforts toward the prevention of drug use.
- Research is necessary to validate the comprehensive community model and its effectiveness.
- The theoretical basis of positive self-image training and resistance skills training is the best curricular design for in-school programming.

BACKGROUND AND NEED (PROGRAM PLANNING)

The public school superintendents of Marion County (Indianapolis, IN) recognized the need for drug prevention education for the youth of Indianapolis in the mid-80's. Reviews of student discipline reports, observations from classroom teachers, and results of national surveys of alcohol and other drug use among young people served as an informal needs assessment and convinced the educators that Indianapolis area schools should take the lead and initiate drug prevention programming for the youth of the community.

Seeking a research-based comprehensive program for the community, the school superintendents identified the Kansas City STAR model as desirable for implementation in their schools. Both programs - Kansas City STAR and Project I-STAR in Indianapolis - are part of the Midwestern Prevention Project (MPP), which was developed and is directed by the Institute for Health Promotion and Disease Prevention Research at the University of Southern California (USC). MPP, Kansas City STAR, and Project I-STAR represent formal research projects as well as educational programs and services to the community. Utilizing a research design funded by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), research staff from USC serve as external consultants and evaluators for the two STAR programs to test the behavioral thesis of the total program.

Working in cooperation with Lilly Endowment, Inc. (private foundation), and the USC research staff, the school superintendents established the service agency called Project I-STAR. The mission of Project I-STAR includes supporting the schools of Marion County and, since 1989, the seven surrounding counties through the training of 1.) classroom teachers in the resistance skills curriculum, 2.) parents in prevention techniques, and 3.) other educators and community leaders in prevention strategies.

Project I-STAR targets the student in the transitional year between grade school and middle/junior high school (6th or 7th grade). Research on adolescent development has suggested that transition years are especially critical for preventive interventions, because adolescents are particularly vulnerable to adoption of problem behaviors such as drug use and at the same time receptive to intervention efforts.

The 11 Marion County public school superintendents serve as the Board of Directors for Project I-STAR guiding an executive director and other staff members in the implementation and ongoing development of the project. When Project I-STAR expanded its service to the seven contiguous counties in August 1989, two public school superintendents were added to the board to represent the interests of those seven counties.

Rather than administering a formal needs assessment, Project I-STAR created a research base by conducting a baseline survey of students in the spring of 1987. The purpose of the survey was to assess the attitudes and behaviors of area students regarding the use of alcohol and other drugs. The survey also was being used as a pre-test to compare changes that are expected to occur in student drug use over a five-year period as the Project I-STAR prevention program is implemented in area schools and communities. A total of 5,890 students in 48 public, three private, and 29 parochial schools in Marion County were surveyed in the baseline study.

In 1987 (measured as <u>within the last 30 days</u>) approximately 35% of seventh and eighth grade students reported consuming one or more alcoholic drinks, 22% reported smoking one or more cigarettes, 7% reported marijuana use and almost 5% reported using smokeless tobacco. Other drug use was measured as <u>ever tried in your life</u>: of the 5,890 students surveyed, 10% had tried "uppers," 9% had tried "downers," 4% had tried LSD, 3% had tried heroin, and 1% had tried cocaine.

GOALS AND OBJECTIVES

The ultimate goal of Project I-STAR is to REDUCE THE LEVEL OF ALCOHOL AND OTHER DRUG USE AMONG YOUNG PEOPLE IN OUR COMMUNITY by helping youth recognize the social pressures to become involved with the gateway drugs (tobacco, alcohol, and marijuana) and illicit drugs. To achieve this goal, Project I-STAR teaches early adolescent children appropriate social resistance skills in order that they can respond to those pressures. Further, Project I-STAR is committed to creating a community environment that supports drug-free youth through a system of well coordinated, community-wide strategies that communicate consistent messages to young people in support of drug-free behavior.

Today's adolescents face a number of serious health problems that not only threaten their survival, but their personal development and psychosocial well-being. Leading the list of adolescent social/health issues is the use of alcohol and other drugs.

Studies have pointed to comprehensive community programming as the best opportunity for effective alcohol and drug use prevention and health promotion. Also, evidence suggests the elements of family, community, and media combined with school programming can make an impact on the harmful use of alcohol and other drugs by youth.

After consideration of these studies and the informal needs assessment, the Project I-STAR Board of Directors adopted the mission to "...***reduce the use of harmful substances among youth by teaching effective resistance skills and by fostering parent and community support.***"

To accomplish this goal, Project I-STAR initially set these objectives:

1. To implement the student curriculum in all I-STAR charter schools by January, 1991

2. To implement the parent program in 50% of participating I-STAR schools by 1992

3. To develop and organize a Community Advisory Council consisting of community leaders representing the media, medical/treatment field, religious community, worksites, youth agencies, education, family, and government by 1990

4. To conduct both a longitudinal and random sample annual survey of Marion County area adolescents to both monitor the behavior and attitudes of students regarding drug use and to evaluate program effectiveness through 1993

5. To increase public awareness of Project I-STAR and the prevention message through presentations, trainings, educational brochures, news releases, networking with other community agencies, video reports, and video and radio public service announcements

At a minimum, Project I-STAR expects to teach every young person who receives the I-STAR curriculum the resistance skills necessary to maintain a drug-free lifestyle.

TARGET POPULATION(S)

In its effort to reduce the level of alcohol and other drug use among young people, Project I-STAR targets the middle/junior high school student. This transition grade from elementary to middle/junior high school (typically grades six and seven) is a critical age, because young people are more susceptible to peer influence at this time compared to other stages in their development and are at greatest risk for beginning experimentation.

Early adolescence is a high risk period for youn[illegible]le, also the one most amenable to change and the one most associated with prevention of onset -- the active use of alcohol, tobacco, and other drugs.

Therefore, Project I-STAR targets a specific age level of youth, middle/junior high school students, with the student curriculum and parent program, but through a comprehensive approach.

The research component of Project I-STAR includes students from grade six through 12. As described in the section on evaluation ("D."), approximately 12,000 students are surveyed annually as part of the I-STAR longitudinal study, which includes both students who did receive the I-STAR curriculum and students who did not, and another 3,000 to 4,000 students are randomly surveyed annually. Project I-STAR obtains background information from each student in order to analyze the survey results in a variety of ways. This information includes gender, race, socio-economic level of parents/guardians, education level of parents/guardians, and occupation of parents/guardians.

However, Project I-STAR considers all youth at-risk for use of alcohol and other drugs.

Project I-STAR requests that all students in the transitional grade from elementary school to middle/junior high school receive the Part I curriculum. Then as those students advance to the subsequent grade, I-STAR requests that all students in that grade receive the Part II curriculum.

Project I-STAR features a community model for effective drug prevention. With the comprehensive approach, Project I-STAR mobilizes the community to send a consistent "no use" message to young people from all their influences in life.

The population of Indianapolis (Marion County) is a mixture of urban, rural and suburban. The following figures were obtained from the Indianapolis Chamber of Commerce and reflect 1980 census numbers:

Total population = 765,233

AGE COMPOSITION		SEX		RACE	
1-14	173,800	Male	= 364,199	White	= 601,092
15-19	70,242	Female	= 401,034	Black	= 155,310
20-24	77,393			Hispanic	= 6,818
25-64	364,497			Other	= 2,013
65+	79,298				

ACTIVITIES AND STRATEGIES

As a comprehensive prevention program, Project I-STAR develops strategies and implements activities to reach its various audiences with the overall goal of reducing the use of alcohol and other drug use among young people.

The Project I-STAR two-part curriculum sets the stage for effective prevention education by targeting the middle/junior high school student. During the I-STAR sessions, specially trained classroom teachers help students become aware of the social pressures to use alcohol and other drugs and equip them with skills to resist those pressures. Part I, a 13-session program, is implemented in the first year of middle/junior high school. Part II is delivered the following year reinforcing the skills students acquired in Part I as well as providing the students with additional skills.

The entire curriculum is activity-oriented with few didactic moments and features role play, assertiveness training, self-image building, problem solving, correction of misperceptions, decision making, and homework with parental involvement. The research-based curriculum incorporates educational methods and strategies proven successful in the classroom such as the Socratic Method, Normative Expectancy, Social Learning Theory, and Diffusion of Innovation among many others.

The I-STAR parent program activates parents in drug prevention through various strategies. The curriculum involves parents in the students' I-STAR homework thereby encouraging parent-child communication about the issue of drugs. To further involve parents in prevention, each I-STAR school establishes an I-STAR Parent Committee to support I-STAR and other drug prevention initiatives in the school. The committee is composed of the school administrator, several parents and frequently students. This core group of parents receive training from I-STAR in prevention strategies and then return to their schools and train other parents in those same strategies. Project I-STAR guides parents in implementing prevention activities in their schools and communities such as obtaining pledges from community members to support drug-free youth, sponsoring I-STAR nights at the school with educational programs, and disseminating posters and decals throughout the school and community.

Project I-STAR enlists prominent community leaders and trains these volunteers in resistance skills and prevention strategies. This group is called the I-STAR Community Advisory Council. Eight action committees were formed from this group to work within their respective organizations to support drug-free youth through specific activities. Activities achieved include:

Government Action Committee
Developed a brochure entitled, "RSVP," that outlines the legal liabilities adults have for condoning or encouraging underage drinking. They distributed these to apartment complexes, schools, parents, and any interested groups.

Media
Sponsors an annual news conference for high school journalists to provide the young people with an educational experience in their field of interest and to involve them in communicating the drug prevention message. Also, sent a cover letter with the I-STAR brochure, "Look Who's Talking Prevention," to area media. The brochure gives guidelines on appropriate terminology when talking or writing about alcohol and other drugs.

Religious
Encouraged the airing of a new Timothy Churchmouse anti-drug video, "Kid Pow Pow Power," on a local television station.

School/Education
Developed a bookmark and found a printer to donate the printing of more than 30,000 bookmarks with the "I-STAR Techniques to Say No" on them. The bookmarks were given to every I-STAR student in the eight-county area.

Youth Agency
Developed and implemented the debut presentation of I-STAR's new Community Youth Activities Package. (This package of 44 drug prevention activities for youth in grades K - 9 was created by Project I-STAR to be used by adults working with youth outside the classroom setting.)

Medical/Treatment
Developing a medical/treatment referral directory for school counselors and area physicians.

Worksite
Approached the 25 largest employers in Marion County and received commitments to promote drug use prevention within their worksites. I-STAR provides these employers with the necessary materials.

Parent/Family
Produced a countertop piece with a tear-away drug prevention message for area businesses' customers and clients to take. The message is to parents giving them tips on how to help their children resist pressures to use alcohol and other drugs.

The Project I-STAR staff and its community volunteers work together with local law enforcement and other community groups in promoting drug-free lifestyles for youth and in affecting social policy. The Government Action Committee and Project I-STAR recently supported an ordinance which was passed in Indianapolis to license vendors who sell tobacco products. The Community Advisory Council includes the chief of police, the sheriff, representatives from the mayor's office, the Governor's Task Force to Reduce Drunk Driving, and others who assist I-STAR in affecting social policy.

By encouraging alternatives to drug use activities, Project I-STAR promotes broad-based wellness; however, I-STAR is alcohol and other drugs-specific in its strategies. Each year in February (winter blahs time) Project I-STAR sponsors a drug-free rap contest open to all children in the eight-county area. The schools advertise the event for I-STAR and distribute the registration forms. The contest is an extension of an I-STAR curriculum activity to involve young people in communicating the prevention message by giving good advice to their peers about not using alcohol and other drugs. I-STAR volunteers assist the staff in the day long event and representatives from the media act as judges.

Also, Project I-STAR is working with the United Way in distributing the new I-STAR Community Youth Activities Package to youth groups, so young people will receive the drug prevention message outside the classroom.

Project I-STAR also produces an annual video which each year focuses on a different aspect of drug prevention and I-STAR. This video is used by staff, schools, community groups, and worksites as an educational tool.

COMMUNITY COORDINATION

Project I-STAR recognizes the crucial role of the community in the prevention of alcohol and other drug use among youth and includes a formal community organization specific to the goals of I-STAR. As mentioned in previous sections, I-STAR identified prominent community leaders and recruited their involvement in Project I-STAR. This group of leaders was trained by I-STAR staff in prevention strategies and became the Project Community Advisory Council. This council was subdivided into eight action committees establishing goals within their respective areas.

Project I-STAR has taken a leadership role in alcohol and other drug use prevention in the community and the state by initiating this grassroots approach to the problem. Project I-STAR was instrumental is developing linkages among the different segments of the community including business, education, government agencies, and youth agencies through the organization of the I-STAR Community Advisory Council.

By the nature of the project's comprehensive model for prevention, Project I-STAR establishes collaboration among all groups of influence to young people. Project I-STAR serves as a resource for the community in drug use prevention. Project I-STAR links with agencies, businesses, and schools.

After creating the I-STAR Community Youth Activities Package, I-STAR connected with the local United Way agency to insure that the packages were distributed to the people who really need them -- youth serving agencies. Also, I-STAR plans to merge information obtained from area treatment agencies for the Medical Treatment Referral Directory, a project of the Medical/Treatment Action Committee, with United Way's data base. With this linkage, valuable information will be shared between the two groups and be available for all interested parties in the community.

The Project I-STAR executive director serves on the steering committee of the Indianapolis regional coordinating council of the Governor's Commission for a Drug-Free Indiana called "I-Challenge." In fact, I-STAR is one of several partner agencies, with I-Challenge, in an application for an OSAP community partnership grant. I-STAR collaborates with the local Indiana Federation of Communities and Governor's Commission for a Drug-Free Indiana.

Also locally, Project I-STAR participates in the Indianapolis Alliance for Health Promotion and serves as presenters for various related conferences such as the Indiana Prevention Resource Center annual conference, the At-Risk Student Conference, the Indiana School Boards Association, and many more.

One major objective is to serve the schools, and I-STAR provides guidance to schools through presentation, publications, and consultation in development and selection of drug education curriculum. I-STAR developed an issue paper, "Effective Prevention Programs for Alcohol and Other Drug Use: A Call for Comprehensiveness," to assist schools. Project I-STAR also participated in the drug education curriculum fairs sponsored by the Indiana Department of Education in the fall of 1990.

Project I-STAR also provides businesses and organizations with presentations on effective drug prevention strategies parents can use. In addition, linkages are constantly being formed between I-STAR and area businesses. Businesses are assisting I-STAR in communicating the prevention message such as a local grocery store chain printing an I-STAR message to parents on all their bags and a drug store chain also displaying an I-STAR message to parents.

EVALUATION

Project I-STAR benefits from a research design which involves both process evaluation and outcome/impact evaluation components.

To document program implementation, Project I-STAR maintains reports, evaluation forms, and training manuals for the student curriculum component, the parent program, the community organization, and the research component. Detailed training manuals are used in training the teachers for the student curricula and for the parents who implement the I-STAR Parent Skills Program at their schools. These are written in a step by step format and an easy to read style with objectives, materials needed, and background provided for each activity in both programs. Evaluation forms are completed by each person trained in these components and are kept by Project I-STAR. Also, each year a committee of selected teachers and parents review their respective training manuals and programs. Review reports are submitted to Project I-STAR by these individuals for annual revision of each program by Project I-STAR.

In the teacher training and curriculum implementation, each I-STAR teacher is observed at least once, often times twice, by an I-STAR curriculum/training facilitator. The purpose of these observations is to see that the curriculum is being implemented as designed and to provide assistance to teachers who demonstrate an inability to follow the curriculum as it is written. These observations are documented, and a form called, "Classroom Observation Scales," is completed by the curriculum/training facilitator for each observation conducted. These are monitored by staff. The I-STAR annual teacher trainings are designed around the needs demonstrated by the classroom teachers. These forms also are given to a research team at Indiana University for detailed analysis. The information is merged with student survey information in order to assess classroom implementation effects on program effectiveness. Also, I-STAR teachers are encouraged to complete and return a "Curriculum Report," which asks specific questions pertaining to the teachers' overall implementation of the curriculum.

To assess the implementation of the parent program, parent facilitators keep a record of all parent programs occurring in each I-STAR school. In addition, an I-STAR parent facilitator attempts to observe at least one of the two I-STAR parent program sessions at each school. Again, the purpose of the observation is to monitor the quality of the implementation and provide assistance to parents who are not implementing the program as written. The visiting I-STAR parent facilitator completes an observation form entitled, "Parent Skills Observation Form," and Project I-STAR uses this in evaluating the implementation of the parent program. No formal evaluation of this information is conducted to date.

The I-STAR Community Advisory Council leads the community organization of Project I-STAR. This council is subdivided into eight action committees (education, parent/family, media, medical/treatment, worksite, government, youth agencies and religious) who establish goals within their respective areas and implement those goals. A Community Advisory Council Manual is provided to each council and action committee member to orient them to drug prevention, Project I-STAR, and their role in prevention. The implementation of the I-STAR community organization is documented by agenda and minutes of all Community Advisory Council quarterly meetings as well as "Action Reports" or minutes of the eight action committees. Also, goals adopted by each of the action committees and the council itself are assessed for completion. Project I-STAR maintains files on these projects and any materials resulting from them.

The research component of Project I-STAR was designed by researchers at the University of Southern California. Extensive records of data collection are kept to satisfy the research design as well as grantors to this research -- National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and Lilly Endowment Inc. Project I-STAR is part of a study called, "the Midwestern Prevention Project," which includes the STAR program in Kansas City and I-STAR in Indianapolis. This study is funded by NIDA. The other grant assisting in the research of Project I-STAR is through Arizona State University from NIAAA.

I-STAR maintains all records of the data collection process from tracking and editing to survey results. Data collection protocol is strictly followed by staff to maintain the validity of the research. Project I-STAR conducts the largest school-based study surveying students in grades six through 12 on an annual basis. Approximately, 12, 000 students are being tracked since the baseline survey was administered in 1987 (the I-STAR longitudinal study) and another three to 4,000 students are randomly surveyed each year (the I-STAR random sample student survey). The longitudinal study follows a group of students who did not receive the program (control group) and a group of students who did receive the program (experimental group). The purpose of these surveys is two-fold: to assess the effectiveness of the program and monitor the prevalence of drug use among the students.

Eight forms with varying amounts of questions (from 111 to 130 different questions) are used in collecting information from the students measuring prevalence in the past week, the past 30 days, and lifetime. Surveys include mainly questions on gateway and illicit drugs, but also questions appear regarding their perception of peer drug use, self-esteem, the latch key issue, alcohol warning labels, extracurricular activities, how students view parents, and students' future plans.

Also, carbon monoxide samples are collected from students to validate their self-reports of smoking habits.

Results of the student surveys are released periodically to the public by Project I-STAR. Preliminary results indicate that ***students who did not participate*** in the I-STAR program were 25% more likely to increase their use of marijuana and 21% more likely to increase their use of alcohol than students who did participate in the I-STAR program. The reduction rates in drug use measured on independent samples of 10th grade Indianapolis area youth are 10 to 50 percent better than national averages.

In the past three years, Project I-STAR has distributed two parent questionnaires and one community leader questionnaire to assess their attitudes and behaviors regarding the drug issue.

Preliminary results from Project I-STAR in Kansas City prompted curricular and program changes including the addition of three lessons focusing specifically on alcohol as a drug. Other innovations resulting from evaluative efforts include accelerated implementation of the community component and collaborative initiatives with other community service agencies.

Chairwoman SCHROEDER. I move along now to Jose Duran.

STATEMENT OF JOSE DURAN, M.C.P., EXECUTIVE DIRECTOR, H.O.P.E. (HISPANIC OFFICE OF PLANNING AND EVALUATION, INC., BOSTON, MA)

Mr. DURAN. Thank you.

I have submitted written testimony.

My name is Jose Duran. I am the Executive Director of the Hispanic Office of Planning and Evaluation. We are celebrating our twelfth year of operation in Boston. HOPE is a leadership development, training and technical resource center, as well as a planner and provider of support services through which successful programs are developed as models and replicated by other agencies to multiply the positive impact on the Hispanic community.

HOPE also serves as an information, communication and community action resource center to gather and disseminate information within the Hispanic community and to the public.

On behalf of HOPE, I would like to thank Chairwoman Patricia Schroeder for inviting me to testify before the committee and to describe HOPE's activities for preventing risky behavior in Latino youth.

I would also like to acknowledge and thank the National Puerto Rican Coalition for recommending HOPE to provide testimony at today's hearing.

The National Puerto Rican Coalition is a national advocacy organization based here in Washington. We are gratified to respond to your request for information about HOPE's youth project which is entitled "Poder Latino de Jovenes," which translates into "Latino Youth Power." In Spanish the word "poder" means "power," but it also means "to be able to."

What we are trying to do at HOPE is provide opportunities for Latino youth to learn that they have the power and that they are able to make changes that are life affirming and health promoting.

Beginning in 1987, as part of HOPE's Hispanic Leadership Development Program, HOPE convened and invited key individuals in the Latino community across the State to a series of forums and roundtables in four areas: education, health, employment and housing.

At the kick-off conference, AIDS was used as the example to highlight the health care status of the Hispanic community in Massachusetts which was described as "islands of third world health care on a continent of first world affluence." Massachusetts' Latino poverty rate (47%) is the highest in the country according to 1990 census figures.

In Boston, three out of every four Latino children are growing up in poverty.

At a subsequent health forum in 1988, HOPE worked with several community-based organizations to design a conference that included first-hand accounts from Latinos and Latinas living with AIDS. Their powerful testimony about life conditions and about living with HIV disease helped to establish and articulate the foundation and the unifying presence that have guided the development of HOPE's comprehensive "Proyecto L.U.C.E.S: Latinos Unidos

Contra El SIDA, Latinos united in the fight against AIDS." In Spanish, the word "luces" means "lights" and we at HOPE are committed to designing and delivering an enlightened approach toward health promotion and disease prevention.

This means we continuously ask those from our community who live with HIV disease about how best we could reach other folks in our community with effective education, prevention and care.

Several HOPE staff are themselves seropositive, living and working with HIV disease. HOPE's basic planning premise and our organizing principles include, without limitation: the need and the benefit of including persons living with HIV and other diseases, as well as those in recovery from substance abuse and their family members, in the design and delivery of health education, disease prevention, and comprehensive care; the efficacy of community-based, neighborhood-based, street-corner-based and home-based approaches and intervention; the urgency of involving youth in early awareness activities that promote total health and livelihood. And if we want teens to listen and to believe, we must include teens in meaningful ways on every level of our prevention efforts.

Our basic planning principles also affirm the wisdom of talking to people of all ages in terms they understand most and in ways that increase the likelihood of their acquiring knowledge and cultivating attitudes that will, in fact, translate into behavior. This can only be a result of designing, delivering and implementing programs and activities in a culturally competent manner. The necessity of taking a fuller view of health risks and health practices, one that takes into account the social, economic, physical and political status of individuals and communities at risk, and the dual necessity of taking a comprehensive view and a reality-based approach to human behavior, one that takes into account other facts of life: substance abuse, physical abuse, sexuality, sexual preferences and practices. And the need for approaches that acknowledge and understand human behavior within the context of people's contemporary realities, and that for many folks includes poverty, racism, sexism, xenophobia, homophobia, and a lack of access to quality education and health care; the lack of jobs at living wages; and the lack of adequate and affordable housing. And the basic requirement of taking a balanced approach toward public health promotion and community problem-solving, one that incorporates both problem-focused and resource-focused perspectives.

Respecting these planning premises, HOPE went about and designed Proyecto L.U.C.E.S. as a comprehensive program of education, prevention and support services that includes these basic components and approaches:

Training and consultation-designing training modules for community-based staff and volunteers utilizing peer education, leadership development, and community-based total health promotion.

Community-based prevention and education intervention—involving youth, parents, family members, neighborhood residents, friends, lovers and loved ones, as well as community-based organizations, merchants and representatives of churches in community-wide prevention and education campaigns and interventions. Information and communication strategies, including visual and performing arts, cultural activities, multimedia educational materials

and interpersonal, street level, grass roots, home-based and neighborhood-based canvassing and outreach approaches as part of an overall social marketing and public information campaign.

Advocacy and support services—mobilizing and fostering the involvement of members from the impacted community, developing peer led support groups, training speakers, forging alliances and building coalitions within our community, as well as networking and linking with other communities and institutions and helping to set up necessary linkages within the overall system of care.

Now I would like to describe in more detail HOPE's program design and model for preventing risky behavior in Latino youth.

The pilot demonstration phase of this intervention has been funded through a subcontract that HOPE has with the New England Research Institute in Watertown, Massachusetts. The New England Research Institute is the prime grantee of a five-year research grant funded by the National Institute of Child Health and Human Development. HOPE's role has been to broker, to design, to coordinate and to implement a two-year intervention involving Latino and Latina youth in 16 census tracts in the Roxbury and South End neighborhoods of Boston.

First let me describe a little bit about the process that led to the design of this project. During the first year, a baseline door-to-door survey was conducted within the 16 census tracts to assess the level of youths' knowledge and awareness about AIDS, to learn about their attitudes towards health risks, and to identify the type and extent of certain behavioral practices related to health risks.

An ethnographic study was undertaken within the research area that took a year for its completion, to learn more about the teens in the area, about their families, neighborhoods and community in terms of knowledge and beliefs about AIDS, substance abuse, sexual attitudes and behaviors, relationships and communication, and about AIDS in relationship to the church, to the health care system, and in relation to other community concerns.

Several roundtable discussions and focus groups were held with community stakeholders, including teens, parents, family members, merchants, folks from the church, and staff from community-based organizations, private and public agencies, so that we could ascertain the boundaries and the tolerance levels for explicit education and prevention messages.

We also consulted, through key informant interviews, with a range of experts in a variety of fields—medicine, social work, psychology, education, public health—and with persons living with HIV disease, persons in recovery from substance abuse, and individuals involved in alternative health care, as well as with persons of various religions, spiritual and political perspectives.

And, finally, we studied many of the available guidelines for AIDS education and prevention, sexually transmitted disease prevention, pregnancy prevention, violence prevention, delinquency prevention, and school dropout prevention to identify quality assurance benchmarks for program design, and also to identify common themes related to the "risky business of adolescence".

The baseline research identified the following risky factors for HIV infection and sexually transmitted diseases: Infrequent or lack of condom use; unprotected anal intercourse—both heterosexual

and homosexual; IV drug use, including steroids and the administration of medication, needle use other than for drug use and abuse, for example ear piercing and tattoos; and a lack of or incomplete knowledge about the risk status of sex partners; and, the frequency of intercourse.

Recommendations based on the ethnographic findings indicated that an AIDS intervention with Latino youth should be community based, target a broad age range, involve community outreach, present factual and explicit information, instill a sense of cultural pride, be bilingual, facilitate a sense of empowerment among teens, utilize peer leaders, and involve parents of adolescents.

There were a number of other recommendations that were advanced in our key informant interviews and community stakeholder focus groups. In the interest of time, those can be obtained from the statement I have entered into the record.

The project designed as "Poder Latino" includes a research and evaluation component, a parent and family module, a peer module, a community organization module, a public information community education and social marketing module, and advocacy and public affairs.

The specific activities of the project include: A 12-week peer educator and leadership development training phase that involves 12 youths per cycle who are paid a training-related stipend and who agree to a contract that commits each youth to participate in peer education activities that are designed to reach other peers. Each trainee works during the school year 10 hours a week and during the summer 20 hours a week. They are paid a training-related stipend of $6 an hour.

To date, we have completed four cadres of 12 youths each and by the end of this year we will have completed four additional cadres.

The activity phase that is simultaneous with and subsequent to the training phase includes an array of options for youth to participate. For example, the youth produce a quarterly newspaper. They make speeches through a youth speakers' bureau. They present group multimedia presentations. They have worked on and have completed radio, TV and print public service announcements. They make site visits to AIDS hospices, to substance abuse clinics, to detox centers and to treatment facilities where the youth have an opportunity to talk with persons living with AIDS and those in recovery.

They participate in neighborhood canvassing, leafletting and public information advocacy activities, including a letter writing campaign in support of the Ryan White Care Act during which these youth helped to generate over 250 letters to their Congressmen and women, something we have difficulty getting adults to do.

There are also recreational, social and cultural activities, including visual and performing arts presentations, and they are currently working right now on a youth enterprise and entrepreneurial project marketing T-shirts, posters, flyers and brochures, as well as music and theater presentations will be available as a revenue generating activity.

We designed a training component for parent volunteers to equip them with sexuality education to conduct home-based sessions with

other parents who, in turn, agree to host and help to conduct other home-based sessions utilizing trained parent volunteers.

We have a staff training component that provides basic health education and prevention training to workers from a variety of community-based settings.

Finally, we have an interagency coalition of community-based organizations, each of which has been awarded, through the HOPE Development Fund, implementation assistance grants to participate as funded partners and to assist in recruiting, sponsoring, promoting and hosting the youth activities.

There is a long list of educational materials that we have also developed. Those are also on the record.

During my final few seconds I would like to address the fourth question that you asked me to speak about, and that is what would be my policy recommendations for improving the health and well-being of Latino adolescents and their families.

We have heard in the testimony today a lot about school-based programs. Those are very, very important. When one considers, however, the high school dropout rates among minority youth, it is critical that community-based organizations and community-based approaches are included in both policy initiatives and in funding.

In the light of the current distribution of AIDS cases in the United States, as well as the demonstrated commitment of Latino and other minority organizations to "own AIDS," and the special capacity of these community-based organizations to provide culturally competent and linguistically appropriate outreach, education, prevention, counseling and treatment, it is critical that these organizations be invited by funders to participate in the development, evaluation and implementation of disease prevention and health promotion efforts.

We need, also, to increase human resource development. Federal research institutes and universities must redouble their efforts to train minority researchers and health care providers. We must examine ways to train staff in community-based settings. And, again, if we want teens to listen, to believe, let's train our adolescents on the front lines of this public health emergency through training-related programs that can provide training and other job opportunities for youth that can possibly lead them to their future careers in public health, public and community service.

And, finally, we need to remove structural barriers. High percentages of Latino and other minority youth and families in the United States are poor, uneducated, unemployed or underemployed, and are at risk of poverty health and face other sociocultural barriers.

These factors account for the disproportionately high rate of HIV disease and other diseases among United States minority communities. Reaching the objectives for Healthy People 2000 will be linked to the extent that there are improvements in these life circumstances for all of our citizens, but particularly for those Hispanic and other racial and ethnic communities that are disproportionately overrepresented among these social problems.

I have one final thing, and that is that we must, in our policies, target teens themselves. Teens in the schools, teens out of schools, teens in the streets, and a forgotten group of teens, and those are

the teens in the juvenile justice system who are neither in school, often not in community-based organizations but somewhere making their way through the juvenile justice system.

Thank you.

Chairwoman SCHROEDER. Thank you very much. We really appreciate that.

[Prepared statement of Jose Duran follows:]

PREPARED STATEMENT OF JOSE DURAN, M.C.P., EXECUTIVE DIRECTOR, H.O.P.E., HISPANIC OFFICE OF PLANNING AND EVALUATION, INC., BOSTON, MA

Introduction: My name is Jose Duran. I am the Executive Director of a private non-profit organization incorporated in 1971 as "H.O.P.E.", the Hispanic Office of Planning and Evaluation. We are based in the Jamaica Plain neighborhood of Boston, Massachusetts and are celebrating our twentieth anniversary this year.

HOPE's mission is to improve the quality of life and to increase the number of life opportunities for Latinos and Latinas residing in Massachusetts. As a statewide multi-service community planning organization, HOPE works with community-based organizations, grassroots groups, public and non-profit agencies, individuals, private firms and employers to increase their capacity to address the needs of the Hispanic community.

HOPE is a leadership development, training and technical assistance resource center, as well as a planner and provider of support services, through which successful programs are developed as models and replicated by other agencies to multiply the positive impact on the Hispanic community. HOPE also serves as an information, communications and community action resource clearinghouse to gather and disseminate information within the Hispanic community and to the public.

HOPE's public policy and advocacy work is focused on the social, economic and political status of Latinos and Latinas in five key areas: (1) Education and Training, (2) Health and Human Services, (3) Employment and Economic Development, (4) Housing and Community Development, and, (5) Civil Rights and Social/Economic Justice.

On behalf of HOPE, its staff, board of directors, and the community and client system we seek to serve, I would like to thank Chairwoman Patricia Schroeder for inviting me to testify before the Select Committee on Children, Youth and Families "to describe HOPE's activities for preventing risky behavior in Latino youth".

Also, I would like to acknowledge and thank the National Puerto Rican Coalition for recommending me and HOPE to provide testimony at this hearing. The National Puerto Rican Coalition is a national advocacy organization based in Washington, D.C. with over 100 organizational members, of which HOPE is proud to be an affiliate member.

We are gratified to respond to your request for information about HOPE's youth project entitled: "Poder Latino de Jovenes" which translates into "Latino Youth Power". In Spanish, the word "poder" means "power" and it also means "to be able to". What we are attempting to do is to provide opportunities for Latino/a youth to learn that they have the power and are able to make decisions that are life affirming and health promoting. That they are able to make a difference in their lives and in the lives of their families and community.

Before describing this model project, I would appreciate the chance to set out some important contexts for how we went about developing this particular project ("Poder Latino"), as well as, for how we designed our overall program ("Proyecto L.U.C.E.S.) which includes a comprehensive array of HIV education, prevention and support services.

By sharing some of HOPE's planning strategies and by using specific program examples, I will attempt to respond to your question "about how prevention efforts can be more effectively targeted to Latino youth". And, I will try to respond to your invitation to share "other policy recommendations...for improving the health and well being of Latino adolescents and their families".

Background information: In Massachusetts, HOPE was the first Hispanic community organization to sound a statewide call to action in response to the disproportionate impact of HIV disease on Latinos and Latinas. When we did so, despite contradictory reports that have appeared and continue to appear in local and national media accounts, we found that there were many individuals and organizations in Latino communities across Massachusetts -- as across the country -- who were willing to 'own' the AIDS epidemic, who were ready to acknowledge its devastating toll on our community, and, who were mobilized to respond to the AIDS crisis within the Hispanic community. What has been, and continues to be, lacking are adequate public and private resources to develop needed education, prevention and care interventions.

Often, the Latino community's response was much sooner and more comprehensive than the extent to which there existed the will, the acknowledgement and the action on the part of government to respond to the health crisis in the Hispanic community with the full force and commitment that is necessary to be effective.

As part of its Hispanic Leadership Development Program, in 1987, HOPE convened and invited key individuals from the Latino community to a series of forums and roundtables in four areas: education, health, employment and housing. At the kick-off conference, AIDS was used as the example to highlight the health care status of the Hispanic community in Massachusetts which was described as "islands of third world health on a continent of first world affluence".

At a subsequent health forum in 1988, HOPE worked with several community organizations to design a conference that included first-hand accounts from Latinos and Latinas living with AIDS. Their powerful testimony about life conditions and about living with HIV disease helped to establish and articulate the foundation and unifying principles that have guided the development of HOPE's comprehensive "Proyecto L.U.C.E.S.: Latinos Unidos Contra El SIDA = Latinos United in the Fight Against AIDS".

In Spanish, the word "luces" means "lights" and we at HOPE are committed to designing and delivering an enlightened approach toward health promotion and disease prevention. This means that we continuously ask those from our community who face life with HIV disease about how best we could reach folks in our community with effective education, prevention and care. Several of HOPE staff are themselves seropositive, living and working with HIV disease, and they are centrally involved in designing, implementing and overseeing HOPE's AIDS/HIV-related work.

HOPE's basic planning premises and organizing principles affirm, without limitation:

- the need and benefit of including persons living with HIV and other diseases, as well as those in recovery from substance abuse, and their family members, in the design and delivery of health education programs,

- the efficacy of community-based, neighborhood-based, street-based and home-based approaches and interventions, and the value of designing, delivering and implementing programs and activities in a culturally competent manner,

- the urgency of involving youth in early awareness activities that promote total health and livelihood; and, that if we want teens to listen and to believe, we must include teens in meaningful ways on EVERY level of our prevention efforts,

- the wisdom of talking to people of all ages in terms they understand most and in ways that increase the likelihood of their appropriating knowledge and cultivating attitudes that will translate into behavior,
- the necessity of taking a fuller view of health risks and health practices, one that takes into account the social, economic, physical and political status of individuals and communities "at-risk",

- the dual necessity of taking a comprehensive view and reality-based approach to human behavior that takes into account other facts of life: substance abuse, physical violence, sexuality, sexual preferences and practices. And, the need for approaches that acknowledge and understand human behavior within the context of folks' contemporary realities, that for many includes: poverty, racism, sexism, xenophobia, homophobia, and a relative lack of access to quality education and health care, jobs at living wages, affordable and adequate housing,

- the basic requirement of taking a balanced approach toward public health promotion and community problem-solving, one that incorporates both problem-focused and resource-oriented perspectives.

Respecting these premises, HOPE designed "Proyecto L.U.C.E.S." as a comprehensive program of education, prevention and support care that includes these basic components and approaches:

Training and Consultation: designing training modules for staff and volunteers utilizing peer education, leadership development, and, community-based "total health" promotion.

Community Prevention & Education Interventions: involving youth, parents, family members, neighborhood residents, friends, lovers and loved ones, as well as, community-based organizations and merchants in communitywide prevention and education campaigns and interventions.

Information and Communications Strategies: including visual and performing arts, cultural activities, multi-media educational materials, and, interpersonal, street-level, grassroots, home-based and neighborhood-based canvassing and outreach approaches as part of overall "social marketing" and public information campaigns.

Advocacy and Support Services: mobilizing and fostering the involvement of members from the "impacted community" (eg. "Latinos/as Living with AIDS/HIV Coalition"), developing peer-led support groups (eg. "Mano a Mano = Brother to Brother"), trained speakers (eg. HOPE Speakers Bureau), forging alliances and building coalitions within our community ("LUCES Leadership Alliance"), as well as, networking and linking with other communities and helping to set up necessary linkages within the overall system of care.

Now, I will describe in greater detail, HOPE's program design and model for preventing risky behavior in Latino youth: "Poder Latino".

The pilot demonstration phase of this intervention has been funded through a sub-contract HOPE has with the New England Research Institute in Watertown, Massachusetts. The New England Research Institute is the prime grantee of a five-year research grant funded by the National Institute of Child Health and Human Development (NICHHD).

HOPE's role has been to broker, design, coordinate and implement a two-year intervention involving Latino and Latina youth in 16 census tracts in the Roxbury and South End neighborhoods of Boston.

We are proud to report that, to date, Poder Latino has been awarded one of two statewide "Youth Achievement Awards" by the Massachusetts Childrens Advocacy Network, one of three statewide "Community Leadership Awards" by the Latino Health Network, and, Poder Latino's public service announcements (radio and T.V.) are also winners in the "Teen Media Contest" conducted by the Boston Initiative for Teen Pregnancy Prevention. In addition, Poder Latino youth recently participated in an AIDS advocacy letter-writing campaign sponsored by the National Puerto Rican Coalition that earned for them a trip to Washington, D.C. during the recent school spring break.

Following is a brief description of the process, structure, and planned outcomes and impacts that HOPE incorporated into the project's design.

1. Process:

1.1 During the first year, a baseline survey of door-to-door interviews was conducted within the 16 census-tract research area to assess the level of youth's knowledge/awareness about AIDS, to learn about their attitudes toward health risks, and, to identify the type and extent of certain behavioral practices related to health risks.

1.2 An ethnographic study was undertaken within the research area to learn more about the teens in the area, about their families, neighborhoods and community in terms of knowledge and beliefs about AIDS, substance abuse, sexual attitudes and behaviors, relationships and communication, and about AIDS in relation to the church, to the healthcare system, and, in relation to other community concerns.

1.3 Several roundtable discussions and focus groups were held with community "stakeholders" including teens, parents, family members, merchants, and, staff from community organizations, private and public agencies to ascertain the boundaries and tolerance levels for explicit education and prevention messages.

1.4 We also consulted, through key informant interviews, with a range of experts in a variety of fields (medicine, social work, psychology, education, etc.), and with persons living with HIV disease, persons in recovery from substance abuse, individuals involved in alternative healthcare, as well as, persons of various religious, spiritual, and, political perspectives.

1.5 We studied many of the available guidelines for AIDS education and prevention, sexually transmitted disease prevention, pregnancy prevention, violence prevention, delinquency prevention, and, school drop-out prevention to identify quality assurance benchmarks for program design and to identify common themes related to the "risky business of adolescence".

2. Structure:

2.1 The baseline research identified the following risk factors for HIV infection and sexually-transmitted diseases:

- infrequent or lack of condom use
- unprotected anal intercourse (heterosexual and homosexual)
- IV drug use (including steroids and medications)
- needle use other than for drug use/abuse (eg. ear-piercing, tattoos)
- lack/incomplete knowledge about the risk status of sex partners
- frequency of intercourse

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2.2 Recommendations based on the ethnographic findings indicated that an AIDS intervention with Latino youth should:

- be community-based
- target a broad age range
- involve community outreach
- present factual and explicit information
- instill a sense of cultural pride
- be bilingual
- facilitate a sense of empowerment among teens
- utilize peer leaders
- involve parents of adolescents

2.3 Recommendations advanced in our key informant and "community stakeholder" focus groups stated that an AIDS intervention with Latino youth should:

- also be neighborhood-based, "streetcorner-based", home-based, and be "transportable" to the variety of settings where risky behaviors take place (eg. "back seat of the car-based");

- address HIV infection prevention within other intrapsychic and interpersonal contexts: sense of self (i.e. self-esteem, social/cultural/political/sexual identity and conflicts, etc.), relationship to others (i.e. the "youths' place in the world", racism, sexism, xenophobia, homophobia) and relationship to the larger world (eg. socio-economic status and class position);

- address "risky behaviors" in the context of their positive attraction as well as their negative consequences: sex, pregnancy, drug use, peer pressure, compulsive and addictive behaviors that provide youth with immediate gratification and transference of those anxieties and stresses that are associated with adolescence and individual circumstances;

- communicate messages to youth frankly ("no bullshit") and in terms they understand and appreciate, by persons they can respect, and in ways that have legitimacy and authenticity from their perspectives;

- balance fear-related messages with those that are life-affirming and offer more positive outlooks than those that attempt to change behavior through fear alone;

- and, to consider what it means, and imagine what it must be like, to be one of many adolescents who perceive the world from an experience where one has heard daily about being poor or disadvantaged, with limited opportunities, and, with fewer chances than others to survive and thrive in what often seems and is a hostile environment. What are the implications of a sense of hopelessness among those teens whose behavior we are seeking to influence?

2.4 The conceptual model for AIDS risk-reduction that was derived from these findings addressed the following dimensions:

Within the context of pride in Latino culture:

- parent influences
- peer influences
- self-esteem
- self-efficacy

Within the context of knowledge/attitudinal/behaviors, skill development and behavioral change or reinforcement:

- health beliefs
- personal and interpersonal practices
- susceptibility
- severity
- benefits
- barriers
- cues to action

Within the contexts of media exposure, school-based and community-based programs, the health care system:

- AIDS/HIV knowledge
- knowledge about other health risks
- health promotion
- disease prevention

The conceptual model assigns a "probability of HIV infection" ("at risk" status) to categories of youth from the target communities, based on evidence from self-reports regarding knowledge, beliefs, and behaviors (in particular, condom and needle use).

2.5 The project design that was drawn from this conceptual model included the following components:

Research and Evaluation: baseline and follow-up interviews with youth in the target research area prior to and following a two-year intervention.

Parent and Family Module: sexuality training of parents and family members to serve as peer educators and to meet in small home-based sessions with other Latino parents to discuss AIDS in the local community and to learn methods for improving communication with teenagers.

Peer Module: based on teen empowerment and leadership development models, training peer leaders to deliver the project's messages to other teens through an array of activities that actively engage youths' interests and participation.

Community Organization Module: providing training, educational multi-media materials, and technical assistance to community-based programs of all types conducted by local service agencies, and, utilizing interagency networks and community-derived coalitions to maximize program impact and to better coordinate services.

Public Information, Community Education and Social Marketing Module: creating appropriate messages and disseminating information that is appropriate and culturally-responsive as part of an overall public information and community education campaign that addresses HIV prevention within familiar and acceptable contexts.

Advocacy and Public Affairs: mobilizing community residents and workers to advocate for increased resources, attention, acknowledgement, and action as part of an overall attempt to develop increased political will and public committment to health education, disease prevention and comprehensive care that addresses the health and well-being of the whole of the body politic.

2.6 The goals of the intervention are:

to increase level of knowledge about HIV disease, sexually-transmitted diseases and other preventable diseases and infections

to decrease and eliminate health-risky behaviors

to increase health-promoting and life-affirming behavioral practices

to increase youth's "self-efficacy" in making decisions about personal and interpersonal behaviors

to increase level of awareness about HIV and about disease prevention among family members, neighbors, friends, lovers and loved ones, and, residents of the community in the impact target area

3. Outcomes: The activities of the project include:

3.1 A 12 week peer educator and leadership development training phase that involves youth who are paid a training-related stipend and who agree to a "contract" that commits each youth to participate in peer education activities that are designed to reach other peers.

3.2 An activities phase, simultaneous with and following the training phase, that includes an array of options: a youth newspaper, youth speakers' bureau, group multi-media presentations (radio, T.V. and print public service announcements), site visits to AIDS hospices, substance abuse clinics, detox centers, and treatment facilities, interviews with youth and persons living with AIDS, neighborhood canvassing, leafletting and outreach at special community events (health fairs, festivals, fundraising walks), and, public information advocacy activities (letter-writing campaigns, public hearing testimony), recreational, social and cultural activities, including, visual and performing arts presentations (murals, T-shirts, posters, flyers, flip-charts, brochures, photo-novelas, music and theatre).

3.3 A training component for parent volunteers to equip them with sexuality education to conduct home-based sessions with other parents who, in turn, agree to host and help to conduct other home-based sessions utilizing trained parent volunteers.

3.4 A staff training component that provides basic health education and prevention training to workers from a variety of community settings.

3.5 An interagency coalition of community organizations, each awarded "implementation-assistance grants" to participate as funded partners and to assist in recruiting, sponsoring, promoting and hosting the youths' activities.

3.6 A variety of educational materials, handbooks and guides, including:

For parents: "50 Questions & Answers Checklist" & Handbook for Conducting "Charlas Con Mis Hijos = Talks With My Kids", and, "trainers guidelines" (with suggested activities and lessons)

For youth: "Entre Nosotros = Among Ourselves" guidelines (for home-based sessions), "Teen Packets" (includes informational brochures, condoms and instructions, brochures, information about how to become involved in Poder Latino), and, a variety of educational materials and products designed to provide basic prevention and resource information (flyers, wallet cards, post cards, decals, bumper stickers, T-Shirts, bags, etc.)

For staff: "Guidelines for Working With Latino Youth" (written by members of the Latinos Living With AIDS Coalition); Training curricula for AIDS education and prevention, sexually-transmitted diseases, other infections (especially Tuberculosis), substance abuse, cultural competence, replication materials related to program planning, project development, staff training and evaluation.

For community: Public displays ("Muestra Tu Respeto = Show a Little Respect"), radio, T.V. and print public service announcements ("Cuida Tu Vida = Take Charge of Your Life" "Quien es Ramon?" "Defiende Tu Cultura = Defend Your Culture"), community celebrations ("Gracias a La Vida" a memorial event to honor those who have died from, and to support those who are living with HIV), visual and performing arts events ("Artists for HOPE" art sale, "Sin Aliento" theatrical presentation) and public art presentations (murals and posters).

4. Impact: (The formal evaluation for Poder Latino will be completed by the New England Research Institute in 1992-93. NICHHD funding for the "Poder Latino" intervention is scheduled to terminate in November, 1991.) Anecdotal accounts, staff observations, parent feedback, youth evaluations, and, pre/post test measures indicate that the intervention has increased knowledge and has had an impact on the behavior of the youth participants of the program, and some adults have also reported their involvement in the program as a positive influence. Of course, w are not able, as yet, to generalize from these anecdotal reports to making impact statements about the total youth population in the 16 census tract research area. Until they are confirmed, or not, by the followup interviews, we will continue to monitor and draw lessons from our experience.

5. Policy Recommendations for Improving Health and Well-being of Latino adolescents and their families:

5.1 Fund Community-Based Organizations: In light of the current distribution of AIDS cases in the United States, as well as the demonstrated committment of Latino organizations to "own AIDS," and the special capacity of these community-based organizations to provide culturally competent and linguistically appropriate outreach, education, prevention, counselling, and treatment, it is critical that these organizations be invited by funders to participate in the development, evaluation and implementation of AIDS prevention and support efforts that are intended to involve youth and their families in health promotion and disease prevention. CBO's represent a vital part of the community infrastructure that needs to be further developed in order to reach targetted communities.

5.2 Increase Human Resource Development: Moreover, federal research institutes and universities must redouble their efforts to train minority researchers and health care providers. Also, we must examine ways to train staff in community-based settings. Let's train our adolescents on the front lines of this public health emergency and assist them with training-related stipends. By creating "training on the job" opportunities for youth perhaps we can establish tracks that will lead to future careers in public and community service.

5.3 Remove Structural Barriers: High percentages of Latino youth and families in the United States are poor, undereducated, un/underemployed, and, are "at risk" of "poverty health" and face other socio-cultural barriers. These factors account for the disproportionately high rate of HIV disease among U.S. Latinos. Reaching the objectives for a "healthy Hispanic people 2000" for Hispanics and other racial and ethnic communities will be linked to the extent there are improvements in the life circumstances of Hispanics and other racial and ethnic communities.

5.4 Target Teens Where They Are: In order to reach teens, our efforts must meet them where they are: in and out of school, in the streets, in the courts and correctional settings, in community programs and at home. Moreover, our efforts must acknowledge and respect teens' perspectives and how they view the world. We must understand that imposing value systems on teens will meet with limited success unless we also expose them to opportunities to succeed in terms that are valued by teens, in terms that are respectful to them, and, in terms they can trust and believe.

Chairwoman SCHROEDER. Our final distinguished witness this morning, who has incredible patience, is Kathleen Sullivan, and we are very happy to have you here, Kathleen. Thank you for hanging in there all morning, and the floor is yours.

STATEMENT OF KATHLEEN M. SULLIVAN, DIRECTOR, PROJECT RESPECT, GOLF, IL

Ms. SULLIVAN. Thank you very much, ladies and gentlemen, for the opportunity to appear before you today.

Does anyone believe that adolescents ought to be sexually active? Does anyone believe that adolescents ought to be involved in drugs? We have asked this question of thousands of citizens across the country over the last six years and have never found anyone who believes that adolescents ought to be involved sexually or involved in drugs. There is tremendous unanimity on this point.

We all agree that it is a problem, a malfunction in society. The evidence of that recognition is the fact that we have developed over the past 20 years enormous programs, organizations, operations at every level of government within our communities to try and combat this malfunction. The disagreement arises when we discuss or decide methods for dealing with this malfunction.

For the past five years Project Respect, of which I have been its director, conducted a study funded through a small grant from the Office of Adolescent Pregnancy Programs, the results of which I do believe you will find very interesting and encouraging. It is attached later.

One statistic that emerged unexpectedly is proving to be very significant. When asked "Are sexual urges controllable,?" students in the course said—28% said "always"—the top they could choose on the pre test—and this increased to 48 percent after the 10-unit course.

But the figure to note is the very small number, only four percent, who said "never" in both the pre and the post tests. This points out that our young people know instinctively that their emotions can be controlled.

What they want to know is: Why should they be controlled and how to control them. If we recognize this as a key to unlocking their attention span, we then find our young people are a lot more responsive then most adults give them credit for.

To the question: "The best way for young people to avoid an unwanted pregnancy is to wait until they are married before having sex," 43 percent "strongly agreed" on the pre test, and that increased to 59 percent after the 10-unit course. Coupled with those who "agreed," the figure was at 88 percent after the course. The number who "disagreed" at the end of the course was only four percent.

To the question; "The best way for young people to keep from getting AIDS or some other sexually transmitted disease is to wait until they are married before having sex," 37 percent who "strongly agreed" before, and that went up to 55 percent "strongly agreed" after; coupled with the "agreed," it was 85 percent after the course. The number who "disagreed" was only 6 percent after.

In fact, the attitudinal improvement has accelerated over the period of the pilot test. One possible reason is the emphasis that abstinence provides the healthiest approach from disease as well as emotion trauma, not just pregnancy. This observation is warranted by studying the higher response among young males over the years. These statistics show that the clear abstinence message not only provides healthier attitudes, but indicates an effect on behavior as well.

Note the improvement from 1988 to 1990 figures. When asked: "Do you feel that sex among unmarried teens is"—one of five different degrees—the figure from 1988 was 20 percent "very wrong" in the pre test, went up to 29 percent in the post. In 1990 it was 33 percent in the pre and that went to up to 41 percent—"very wrong"—after.

A very challenging question in our pre and post test is in relation to what we call "secondary virginity," and that gets tremendous satire and sarcasm from the press and some others. When asked: "A teen who has had sex outside of marriage would benefit by deciding to stop having sex and wait for marriage," they could answer one of five answers. In 1988 the top one—"absolutely true"—went from 17 percent in the pre to 33 percent afterwards. The 1990 figure showed 28 percent pre and 44 percent afterwards.

Another statistic that needs much more attention is that 94 percent said it was "important" when asked: "If you were pregnant or had gotten someone pregnant, how important would it be to share this problem with your parents?" This contradicts—94 percent said it was "very important." This contradicts the often heard statement that youngsters cannot, or will not, talk to their parents.

The very format of our two texts, which are "Sex Respect" and "Facing Reality", include a special separate parent guide, which is proving to be a good bridge for building communication between home and school.

While most programs in the past were set up under the general term of teen pregnancy, we now note this gives the appearance of it being a female problem. We also now recognize that pregnancy is only one factor of the problem. Actually, it is an outcome of the problem. The problem really is adolescents being sexually active.

We all currently recognize the numerous diseases that are rampant. There are over 30 sexually transmitted diseases, and teens are leading the age group in most of these.

The CDC shows the greatest jump in the number of full-blown AIDS patients is in their 20s, which means they contracted the disease as teenagers.

We must also give far greater attention to the emotional trauma growing among our adolescents to date. Another finding of our evaluation was the correlation of sexual activity with alcohol and drug use. Most students involved in one are involved in two or three. I refer you to graphs 9 and 10 of our OAPP Final Report. We point out to students that when under the influence of alcohol and drugs, emotions are high and resistance is low.

We must direct our teens to the evidence. Is there such a thing as safe sex? No. Only safe partners.

How can society insure that our young people will be healthy, safe partners when they grow up? By giving them the complete in-

formation for what constitutes a truely healthy lifestyle. That is, teaching true abstinence.

This information should include that no amount of contraceptives can prevent the emotional trauma of adolescent sexual involvement. All contraceptives have failure rates, and, in particular, the frightening failure rates of condoms.

While doing an interview on the NBC Nightly News last December, it became evident from a statement made by a student that our young people do not know that for years established research has shown the condom to be the least effective form of birth control.

In my 90-second sentence "sound bite" reply, I explained that our young people did not know about the past research of condom failure, whose rate among the adult population is 10 percent and among teens it is 19 percent, and that these statistics of failure were regarding conception where only one of the partners, the female, could conceive for a mere four or five days of a month.

In the transfer of disease, the failure rate is much more likely 50 to 60 percent, as each partner can contract or transmit that disease every time.

My opponent, who had a second chance to speak, responded, "But that is all we have." My plea, "No, it isn't. We have the choice of abstinence, the real healthy lifestyle for our youth," did not get aired.

It has been very unfortunate over the past two to three years that the impression has developed that abstinence programs are not successful. It is amazing to those of us working day to day with the enthusiastic response of students and teachers to hear even certain Senators and Congressman say, "Just Say No" programs don't work. Maybe it is because they do not know that, in fact, abstinence education is not a "Just Say No" approach. We teach the kids to be able to ask and answer what part of "no" don't you understand. They have told us that they pull these "No" cards out on a date, and it guarantees two hours of communication instead of action.

Abstinence is really what should comprise a comprehensive health course for sex education. We are hopeful that through this committee, now that we are being given the chance to share our research and show the effectiveness of one demonstration project, you will advance the abstinence concept through every available outlet.

The cost effectiveness is exceptional, as can be demonstrated from our pilot schools over the past six years. At the Federal level, Project Respect received $107,500 for last year, out of approximately 1.3 million of Title XX appropriation, which, as far as I know, is the only money spent on abstinence at the Federal level.

In the State of Illinois, there is a program called Parents Too Soon, instituted in 1983, with a budget of 6 million. This current year its budget is $21.7 million. Over a period of a year and a half, I, as well as other parents, were assured verbally that they taught abstinence, but all the evidence we were ever given in materials were four posters.

After much negotiating and with a statement from our then Governor James Thompson, which stated that abstinence should be

stressed at least as much as other types of programs, Project Respect was able to get a small portion of funding three years ago for schools which wanted to implement the Sex Respect curriculum and which we could not accommodate in our Federal pilot program.

This year, the abstinence component is still under only one percent of the PTS budget. However, we have served 12,000 students in 75 schools throughout the State of Illinois and have put on 13 community seminars in this current year promoting abstinence as the healthiest lifestyle, with only $320,000 out of the 21.7 million.

According to the Auditor General's report of June, 1990, Project Respect and one other are the only two of 320 contracts let by Parents Too Soon Program, which even did any evaluations at all. The auditor's report concluded that, over all, Parents Too Soon "officials could not determine which program strategies and elements were effective, ineffective or even counterproductive."

As noted at the beginning, there is an overwhelming consensus in the belief that adolescents should not be sexually active. We urge you to carefully study the results of our demonstration project and to give us the opportunity to have teachers, parents, principals and students appear before you and give evidence as to the support and acceptance of the abstinence concept.

I feel confident that upon becoming fully briefed as to the encouraging results, you will recommend that a substantial portion of all funding ought to go to straight abstinence education. I am not referring to new money or new programs but redirecting of existing moneys.

In view of the fact that what has been predominantly taught for 20 years has not worked, it is only fair and just to the taxpayer parents who want our youngsters taught the healthiest lifestyle, that the major part of all government funding should go to straight abstinence.

We are constantly told that kids having kids are costing more and more dollars. Let me ask you to analyze that these kids who are having kids are themselves products of the nondirective, nonjudgmental approach to sexuality that has been in existence for the past 20 years. Is this not substantial proof that we need a new approach?

Recently, in Rockford, Illinois, I was told the cost of psychiatric care for a teen who attempted suicide was $500 per day. If we can keep these youngsters healthy, we can save millions.

Abstinence is inevitable, as expressed by numerous people at all levels today, including Governor Douglas Wilder who said, and I quote, "If these young men and women want to have a future, it is imperative that they embrace the ultimate precaution: Abstinence."

A promiscuous lifestyle is unhealthy, regardless of the sex of one's partners, it is a matter of facing reality.

Since we can show promising results with a minuscule appropriation of under 1 percent, we have every reason to believe that with 10 percent we could show quite an impact. With 50 percent of what is now spent, we could probably solve the problem, saving hundreds of millions of the government budget and saving millions of our students from trauma, and disease, as well as death.

Thank you very much.
Chairwoman SCHROEDER. Thank you very much.
[Prepared statement of Kathleen M. Sullivan follows:]

PREPARED STATEMENT OF KATHLEEN M. SULLIVAN, DIRECTOR, PROJECT RESPECT, GOLF, IL

Ladies and Gentlemen:

Thank you for the opportunity to appear before you today.

Does anyone believe that adolescents ought to be sexually active?

Does anyone believe that adolescents ought to be involved in drugs or alcohol?

We have asked this question of thousands of citizens over the last six years and have never found anyone who believes that adolescents ought to be sexually active or involved in drugs.

There is tremendous unaminity on this point! We all agree that it is a problem, a "malfunction" of society. The evidence of that recognition is the fact that we have developed over the past 20 years enormous programs, organizations, operations at every level of government within our communities to try and combat this "malfunction".

The disagreement arises when we discuss or decide methods for dealing with this malfunction.

For the past five years Project Respect conducted a study funded through a small grant from the Office of Adolescent

Pregnancy Programs (O.A.P.P.) the results of which I do believe you will find very interesting and encouraging.(1)

One statistic that emerged unexpectedly is proving to be very significant.

When asked, "Are sexual urges controllable?"

28% said "Always" on the pre test in this past year and that went up to 48% on the post test. But the figure to note is the very small number, 4%, who said "Never" in both the pre and post tests.

This points out that our young people know instinctively that their emotions can be controlled. What they want to know is:

WHY should they be controlled and

HOW to control them.

If we recognize this as a key to unlocking their attention span, we then find our young people are a lot more responsive than most adults give them credit for.

To the question:

"The best way for young people to avoid an unwanted pregnancy is to wait until they are married before having sex."

43% Strongly Agree on the pre test and 59% after the course, coupled with those who "Agree", the figure is 88% after the course. The number who disagree at the end of the course is only 4%.

To the question:

"The best way for young people to keep from getting AIDS or some other sexually transmitted disease is to wait until they are married before having sex."

37% "Strongly Agree" before the course, 55% after, coupled with the "Agree" it is 85% after the course. The number who "Disagree" is only 6% after.

In fact, the attitudinal improvement has accelerated over the period of the pilot test. One possible reason is the emphasis that abstinence provides the healthiest approach from diseases as well as emotional trauma, not just pregnancy. This observation is warranted by studying the higher response among young males over the years.(2) These statistics show that the clear abstinence message not only provides healthier attitudes but indicates an effect on behavior as well. Note the improvement from 1988 to 1990 statistics:

When asked: "Do you feel that sex among unmarried teens is?"

A. Very Wrong B. Quite Wrong C. Not Very Wrong D. Not Wrong at all E. No Response

The figures for 1988 were 20% "Very Wrong" in the pre and 29% in the post. In 1990, it was 33% in the pre and 41% in the post.

A very challenging question in our pre and post survey is in relation to what we call "Secondary Virginity".

When asked: "A teen who has had sex outside of marriage would benefit by deciding to stop having sex and wait for marriage."

They could answer one of five: A. Absolutely True B. Very True C. Somewhat True D. Not True at all E. No Response

The 1988 figure went from 17% in the pre to 33% in the post. The 1990 figure was 28% pre to 44% post.

Another statistic that needs much more attention is that 94% said it was important when asked, " If you were pregnant or had gotten someone pregnant, how important would it be to share this problem with your parents?" This contradicts the often heard statement that youngsters cannot or will not talk to their parents.

The very format of our two texts include a special, separate Parent Guide, which is proving to be a good bridge for building communication between home and school.

While most programs in the past are set up under the general term of "teen pregnancy," we now note this gives the appearance of it being a "female" problem. We also now recognize that pregnancy is only one factor of the problem, actually it is an outcome of THE problem!

THE problem really is adolescents being sexually active.

We all currently recognize the numerous diseases that are rampant. There are 53 known sexually transmitted diseases,(3) and teens are leading the age groups in most of these. The CDC shows the greatest jump in the number of full blown AIDS patients is in their 20's (4), which means they contract it as teenagers. We must also give far greater attention to the emotional trauma growing among our adolescents today.

Another finding of our evaluation was the correlation of sexual activity with alcohol and drug use, most students involved in one are involved in two or three.(5)

I refer you to Graphs 9 and 10 of our O.A.P.P. Final Report. We point out to students that when under the influence of alcohol and drugs, emotions are high and resistance is low.

We must direct our teens to the evidence.
Is there such a thing as "safe sex"? (6)
No, only safe partners.

How can society insure that our young people will be healthy, safe partners when they grow up?

By giving them the complete information for what constitutes a true healthy lifestyle, e.g. teaching true abstinance.

This information should include that: no amount of contraceptives can prevent the emotional trauma of adolescent sexual activity (7), ALL contraceptives have failure rates (8), and in particular, the frightening failure rates of condoms.

While doing an interview on the NBC Nightly News last December, it became evident from a statement made by a student that our young people do not know that for years established research has shown the condom to be the LEAST EFFECTIVE form of birth control.

In my 90 second santence (TV sound bite) I explained that our young people did not know about the past research of condom failure, whose rate among the adult population was 10% failure and among teens 19%, and that these statistics of failure were regarding conception where only one of the partners, the female, could conceive for only 4 or 5 days of the month. In the transfer of disease, the failure rate is more likely 50% to 60% as each partner can contract or transmit a disease every time.

My opponent who had a second chance to speak, responded "but that's all we have."

BEST COPY AVAILABLE

My plea: "No it isn't, we have the choice of abstinence, the real healthy lifestyle for our youth," did not get aired.

It has been very unfortunate, over the past 2 to 3 years, that the impression has developed that abstinence programs are not successful. It is amazing to those of us working, day to day, with the enthusiastic response of students and teachers to hear even certain senators and congressmen say, "Just say No" programs don't work.

Maybe it's because they do not know that, in fact, abstinence education is not a "just say NO" approach.

Abstinence is really what should comprise a "comprehensive health" course for sex education.

We are hopeful that through this committee, now that we are being given the chance to share our research and show the effectiveness of one demonstration project, you will advance the abstinence concept through every available outlet.

The cost effectiveness is exceptional. As can be demonstrated from our pilot schools over the past six years. At the Federal level Project Respect received $107,500 for last year out of approximately $1.3 million of Title XX appropriation. Which, as far as I know, is the only money spent on abstinence.

In the state of Illinois, there is a program, Parents Too Soon, instituted in 1983 with a budget of 6 million. This current year it is 21.7 million. Over a period of a year and a half, I, as well as other parents, were assured verbally that they taught abstinence, but all the evidence we were given in materials were 4 posters.

After much negotiating, and with a statement from our then Governor James R. Thompson (9) which stated abstinence should be stressed "at least" as much as any other type of program, Project Respect was able to get a small portion of funding three years ago, for schools which wanted to implement SEX RESPECT and which we could not accommodate in our Federal Pilot program. This year, the abstinence component is still under 1% of the P.T.S. budget. However, we have served 12,000 students in 75 schools throughout the state of Illinois and have put on 13 community seminars, in this current year, promoting abstinence as THE healthiest lifestyle, with only $320,000.

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In view of the fact that what has been predominantly taught for 20 years has not worked, it is only fair, and in justice to the taxpayers/parents who want our youngsters taught the healthiest lifestyle, that the major part of ALL government funding go to straight abstinence.

We are constantly told that "kids having kids" are costing more and more dollars. Let me ask you to analyze that these "kids," who are having kids, are themselves products of the non-directive approach to sexuality, that has been in existence for the past 20 years. Is this not substantial proof that we need a new approach? Recently in Rockford, Illinois, I was told the cost for

psychiatric care for a teen who attempted suicide was $500 per day.

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A promiscuous lifestyle is UNHEALTHY, regardless of the sex of one's partners is a matter of facing reality.

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Chairwoman SCHROEDER. Congressman Wolf, do you have any questions?

Mr. WOLF. I do. I want to thank the panel for all the testimony. I have a number of questions, and I will try to be relatively brief and maybe ask a couple to each of you.

Mrs. Zedosky from West Virginia, do you have any evaluations? When did you set the program up?

Ms. ZEDOSKY. The model program in Harrison County was set up in 1987, and we do have an evaluation that shows a significant increase in knowledge. That program is in elementary schools.

The other programs I described are our vision and our plan for comprehensive initiatives statewide.

Mr. WOLF. So the senior high programs are not in effect? What are your plans and goals?

Ms. ZEDOSKY. We have comprehensive health education programs in place. The other parameters, such as the teacher wellness, health service, counseling components, are not fully in place.

Mr. WOLF. I see. Will West Virginia be putting them in place?

Ms. ZEDOSKY. This is a commitment from our Governor and our committee. We will be putting them in place.

Mr. WOLF. What did the evaluation of the elementary school show in 1987?

Ms. ZEDOSKY. It showed that when the children personalized their health behavior and understood their own ownership of that, they made significant improvement in diet and exercise habits, their cholesterol levels decreased, and their self-esteem increased significantly. There were interesting drawings that the children did of themselves pre-and post-program that indicated that they did understand that they could control much of what happened to themselves and their health.

Mr. WOLF. Could you send us a copy of the evaluation?

Ms. ZEDOSKY. I'll be glad to.

Mr. WOLF. Thank you.

Ms. McKee, I want to welcome you. I know you are a famous person. I saw you on television. You said something that I found to be very true. You made the comment about being free from embarrassment. When I was a kid, I stuttered very badly. I experienced embarrassment and fear in school as a result of my stuttering.

I think a teacher like you can raise the comfort level in the classroom by coming to the defense of the child that is not quite sure.

So I think you have really struck a nerve. I wondered what do they do in senior high school? You are speaking more from elementary experience, I assume.

Is there anything like this in senior high schools that you are aware of?

Ms. MCKEE. Our senior highs and high schools do have a guidance counselor in place. There is one health nurse that serves an entire county population, which, of course, limits very much what she can do for children.

We found, of course, that one guidance counselor at our one high school in Hampshire County, which is servicing about 450 students, is just not adequate in any way, shape or form to meet the needs of these students.

It falls very much on the high school teachers, to become mentors and caregivers of individual students. It is quite a burden to bear.

Mr. WOLF. Thanks.

What about parent involvement?

Ms. MCKEE. We have a very limited parent involvement. In fact, I have been very active over the last several years in trying to carry on workshops with parents, make home visits myself, to try to get parents involved. Involvement isn't even the terminology that I am striving for.

I cannot get parents to even sign a release form for me to take their child to the doctor in my car.

I often have to go to the home and show them where to sign, so that I can take their child. That is the minimum standard of what we would term as involvement.

Mr. WOLF. Why is that?

Ms. MCKEE. Simply because many of the families are trying very hard just to exist. They see me and see the school as the only hope that their child has of being somewhere where he can get a warm meal and someone to care for him.

The papers don't get home. The parents very often cannot read the papers.

Mr. WOLF. Thank you.

Ms. Wodraska, do you have any evaluation of your program? It sounds like you do. How long has it been in effect?

Ms. WODRASKA. Our program has been in effect since 1987. Our sister program in Kansas City has been in effect since 1984.

Mr. WOLF. How old are the children when they first enter the program?

Ms. WODRASKA. Either in middle school or junior high, which would be approximately 11, 12—10, 11, 12. It depends on the structure of the school. It is a two-year program. They come in either in the sixth or seventh grade, or the seventh or eighth, depending on the school.

Mr. WOLF. Have you seen improvements?

Ms. WODRASKA. Great improvement. We have the largest longitudinal study in the Nation. It is included in my written testimony.

Of the results we have published the findings, and what we have done when we were looking at the Kansas City findings, obviously we were lucky.

While it wasn't as strong as we would like to have seen, we made improvements and in particular, we didn't see as strong of a reduction in alcohol in Kansas City as we would have liked.

And so in Indianapolis, we wrote three lessons that were specific to alcohol as a problem. When we look at the use of alcohol as opposed to marijuana and cigarettes, the acceptance, the social norm, the acceptability of alcohol really impacts on the results.

But this did help. So those are the kinds of program innovations that we made from Kansas City.

But we have extensive research on that. We also do informal types of research. We do informal surveys as part of the actual program curriculum from the youngsters. Self reports that help us verify what we are doing in our other types of research.

Mr. WOLF. Is this anything like the D.A.R.E. program?

Ms. WODRASKA. Well, it's interesting that you should ask. We had the same birth process. Over 11 years ago, the program called Project Smart was initiated in Los Angeles, designed by the same people at the University of Southern California, and from that program eminated Project Star and Project I-Star.

The original Project Smart was placed in the fifth grade level, fourth and fifth grade level, and they found through the research that that was not the most effective for the social skills approach that we used.

And so, when it was transferred to Kansas City and Indianapolis, we moved it up a little bit, and we found that our research indicates it is more effective.

Mr. WOLF. Moved it up from——

Ms. WODRASKA. One grade level.

The D.A.R.E. program keeps it at the original level where it was placed. The D.A.R.E. program has a unique objective of trying to integrate the policeman into the classroom which I think is a very fair objective.

And what we have done in Indianapolis is actually take those communities where the police want to get involved, and we train them to "team teach" with the teacher.

The differences I see in the D.A.R.E. program is that they relegate the teacher to a monitor in the back of the room, and yet your teacher has that ongoing consistent influence with the youngsters all year long.

So we have kind of married both objectives, the objectives of the police department in wanting to have a presence, a positive presence in the classroom before their relationship becomes punitive with the youngsters, and the fact that you have an ongoing professional teacher, and they can work together and long after the policeman is out of the classroom, you still have the teacher giving the consistent message.

So we believe that our initiative in Indianapolis is going to be much stronger than the actual D.A.R.E. program.

Mr. WOLF. We have D.A.R.E. in two of my counties, in Arlington County and Loudon County; and they seem to feel it is good, although I haven't seen the evaluations.

I think it started in L.A., and apparently the evaluations out there are fairly good.

Do you think yours is better?

Ms. WODRASKA. I believe it is. There is an extensive research conducted by Dick Clayton.

Mr. WOLF. Is it favorable or unfavorable?

Ms. WODRASKA. Over a three-year period, it does not seem to indicate that there is a cause and effect to programming.

Mr. WOLF. Could you send that to me, and could you give us a copy of your program, and a synopsis of it, so that I could send to my local counties?

Ms. WODRASKA. Absolutely. Sure could.

[The following information requested is retained in comittee files.]

1. News release of November 20, 1990, highlighting Project I-STAR's most recent high school data.
2. Prevention News Reprint featuring I-STAR Survey Results.

3. I-STAR police/school initiative recommendations.
4. "Cops, Kids, and Drugs," conference paper by Everett M. Rogers, Annenberg School for Communication, University of Southern California.
5. I-STAR Brochure.

Mr. WOLF. Are there other states that are doing what you are doing?

Ms. WODRASKA. We have a public-private partnership. Our research is somewhat underwritten by Unite-A-Grant through U.S.C., but our program itself is funded by a local funder, Lilly Endowment, in Indianapolis, and by Mary Dow Kaufman Association in Kansas City.

So there aren't many communities just yet that can find that public-private partnership.

Our program is offered at no cost to all of the communities, and schools that we serve in an eight-county area, which is quite unique.

Mr. WOLF. Does it require a lot of parent involvement?

Ms. WODRASKA. A lot. As I indicated before, we bring the parents in—I thought it was interesting, Mr. Riggs had said he had to be involved in the program. We involve the parents in the actual curriculum through homework where it opens up a focused dialog to discuss, with your youngsters, the drug issue.

We involve them in training so that they can train other parents in prevention strategies and parenting skills, which is unique.

Oftentimes, you have a parent program that has a professional deliver to parents. Well, here we train our parents to deliver to other parents, saying "Look, we have the same problems, we can solve these together."

And then we involve them in community organizations so that they can actually go into the community and require that the public policies that are in place about not selling cigarettes to minors and alcohol, that indeed the local merchants are complying.

So we really empower the parents, and that is one of the unique features of our program. It is a—when we say comprehensive, it really is comprehensive because we involve everybody, the parents, the community, the media.

Based on our research, we say that we are research based and research driven, and we indeed are.

Mr. WOLF. Is it available in all Indiana schools?

Ms. WODRASKA. No, sir. It began in Marion County, which is Indianapolis, and in the seven contiguous counties that border that.

We have a layered approach.

And Lilly Endowment was very favorable to us moving out in the layer process. However, our full funding from Lilly will cease in 1993 unless they become extremely generous again and give us more as we move throughout the state.

Mr. WOLF. Is it just in Indianapolis then?

Ms. WODRASKA. I hope not. We will be looking for additional funds. We have a very good base. We just received our second national award last August.

In May of last year, the AMA recognized us out of 140 other programs for excellence in prevention programming, and from the U.S. Secretary of Health and Human Services, Louis Sullivan, we

earned that award in August for excellence in prevention programming.

Mr. WOLF. Well, if you could send me a synopsis of it and also the D.A.R.E. report, because I have co-sponsored every year with another Member the resolution commending the D.A.R.E. program, and I would like to see it.

I would also like to send that to the schools in my district.

Mr. Duran, I appreciate your testimony. It sounds like you have a pretty good program going there.

I just wondered, one question. Do you get into values at all? Do you get into things like that?

You said you had parental involvement, and it is community based, but I wonder, do you get into values, right, wrong, and this is appropriate and this isn't appropriate?

Mr. DURAN. Yes, it is a very value-based program. It would differ, if you are talking from the parent component to the community organization component to the peer component, and the approach is to try and reach the teens, reach the parents, and reach folks in the community wherever they are.

And when we have done that, we have seen a wide range of different values.

Mr. WOLF. Do you have an evaluation of how successful you are?

Mr. DURAN. The evaluation is slated for next year and the following year. The intervention itself will terminate—rather, the Federal funding through NICHD for the intervention will terminate this November, and the Research Institute will then do the follow-up survey all of next year, and then the analysis the year following.

Mr. WOLF. OK.

I would almost be tempted, Ms. Sullivan, I am running out of time, to ask the others to comment on your approach with regard to abstinence. And I wanted to ask you a couple of questions.

I wrote a couple of notes down in pages. On Page 6, you had the failure rate of condoms. What do you base that on?

You explained how young people did not know about the past research of condom failure. You said the rate among adult populations was 10 percent failure and among teens 19 percent.

And these statistics of failure were regarding conception where one could possibly conceive for only four or five days of the month.

In the transfer of disease, the failure rate is more than 50 to 60 percent because each partner can transmit a disease every time. Where do you come up with these figures with regard to the failure rate of condoms in relation to pregnancy and also the failure rate in relation to disease?

Ms. SULLIVAN. The failure rates of contraceptives is detailed in contraceptive failures in the United States estimates from the 1982 national survey, which was in *Family Planning Perspectives*, as well as the more current one, which was also in *Family Planning Perspectives*, 1986 and 1984.

And these are——

Mr. WOLF. Could you submit them for the record and let me see a copy of that?

Ms. SULLIVAN. Yes, yes, I certainly will.

There is also an interesting thing. As far as I know, maybe Dr. Kolbe could comment. We have been trying to get whether or not there have been any studies done of condoms failure rates for disease.

And as far as we know, there were only two attempted. One was among married couples in Florida, and one was started UCLA which was discontinued because they realized they were literally spreading the disease at such a high rate.

And this is of great concern. Now we did a very grassroots survey at my office, which was not funded by any grant anywhere, and took just a matter of going to the drug store. And we bought five different condom products, by the way, and read the instructions inside, which I think is something that as far as I know is not done with any of these youngsters among the programs that hand out condoms so liberally.

And each package said, "this product recommended for vaginal use only," and it gave no reference to failure rates, which I thought was interesting.

It is the only product I know of today that literally does not even give an indication of its failure or effectiveness.

Now, the point is very serious, though. They are only really safe if they stay in the package and they are never used. We all know, all women knew for years and years and years that you didn't really depend on condoms to prevent conception.

And yet all of a sudden today in the last three to four years, it is being referred to as "the only thing we have" in a life and death situation. Where pregnancy is not—you know, a child is not a death sentence.

When it comes to AIDS and sexually transmitted diseases today, it can be a death sentence. And yet we are misleading our youth. Where is truth in advertising when it comes to information regarding sexual activity among our young people?

What I am pleading is, it simply isn't being covered.

Mr. WOLF. I think you raise a very good point.

Doctor, do you know? Have there been studies pertaining to the transmission of disease with regard to the failure rate of condoms?

Dr. KOLBE. There have been some fairly recently, and there are experts in our Division of Sexually Transmitted Diseases and Division of Reproductive Health that could testify.

Mr. WOLF. Do you know what the failure rates are?

Dr. KOLBE. I am sorry, I don't.

Mr. WOLF. That is important. Otherwise, you may literally be playing a game of Russian roulette whereby a young person can die.

If you could submit them for the record and then I will have my staff check with the Food and Drug Administration and Dr. Sullivan's office to see if there are any more recent studies.

If you could submit them, Doctor, I would appreciate it.

Ms. SULLIVAN. Excuse me, Congressman.

This is an ad from one of the condom producers. This particular ad is in regard to latex gloves, but it applies to latex condoms, also.

And it is really quite graphic. We have found this is a wonderful demonstration in the classroom. This is what a pinhole looks like to a virus, and when the kids realize this is what we are talking

about, they are much less likely to trust their lives to one little piece of latex in an emotional situation.

Mr. WOLF. Well, that is a very good point. I guess in closing, let me thank the panel. This is a tough issue. Let there be no mistake. I come down on the side of abstinence. I believe that is the appropriate response.

Now, let me just say publicly, there are some good families and good people that get involved and mistakes happen, and I understand that. I listened to a radio program today of a man who had a daughter, 14 years old, who became pregnant. She was from a good family and they had done everything possible. I understand that things still can happen. You have to love this girl and help her.

But I think overall when you are young, you need to have the leadership of your parents and the community and of the groups like yours, Mr. Duran, and the West Virginia school system. If they can say, abstinence is the approach, and instill values, I think that is very, very important. Particularly not only when you are dealing with the issue of pregnancy but when you are dealing with the issue of death. To have a young person come down with one of these diseases and die, no matter what the case is, your heart goes out to them, and you just want to do everything you can.

I think, Ms. Sullivan, you make a very good point with regard to the question of abstinence. I also think it is important, and I don't know how we accomplish this goal.

Ms. McKee, I wish I had had you for a teacher. I had some great teachers and some who weren't as great, but I think you would be very sensitive to a young kid who stuttered and didn't know what he was going to do later on in life.

But I think that more institutions can raise the comfort level of these young people. I think they are looking for role models, they are looking for somebody who is willing to say that this is wrong.

And Friday night after I gave a graduation speech, my youngest child (I know I don't look old enough to have five children who have graduated from high school, but I do, and I am only kidding) we had an all-night graduation party, and the graduation party went from 11:00 o'clock until 5:00 o'clock in the morning; no drinking. My wife and I were there.

Part of our job was the clean-up crew, and I watched these kids and you could just see their comfort level having increased because a lot of their teachers were there, a lot of the parents were there, and it was okay not to drink.

They were playing games and doing things, and since Fairfax County has had that program, there has not been one accident, nor one death. I would urge every county, every school to look at this program. You might want West VA to look into it.

Up until that time, you would constantly hear a report about a kid on the way home from a graduation party who was killed. Then you think of the hurt and the pain and the suffering of the family involved. Every time I hear a story like this I think of Mike Barnes who was a Congressman from Maryland, a Democrat. I just think of how good he would feel knowing it was his legislation to raise the drinking age from 18 to 21.

I have often told him, Mike, as a result of what you have done, you have probably saved more hurt and pain and suffering and

agony in a family, and they don't even know that you have saved them because they didn't lose their loved one.

But if you hadn't done that, they would have gotten the telephone call 2:30, 3:00 o'clock in the morning from the State Police, that there had been an accident.

As a result of Barnes doing that, he saved a lot of lives. I think if we do things where the structure, the government, the church, the different communities groups like yourselves, Mr. Duran, tell the kids, this is what we believe and these are the parameters; you don't have to drink, you don't have to do these things; I think it can make a tremendous difference.

To those kids who do it, I think we should just put our arms around them and tell them we forgive them, we love them, we care for them, and get them back on track.

I had never heard of the term you called secondary virginity.

Ms. SULLIVAN. It is a very, very definite "attention getter," and when they listen and discuss through it, they realize they may never regain their physical virginity, but they can regain the emotional virginity, the psychological. And they can start all over again. And that is really what we are aiming at with all these programs.

If I might just comment once more, our statistics show very clearly the correlation between the drinking, drugs and sexuality; and that is why our new textbook, "Facing Reality," is the composite approach.

Mr. WOLF. When does that come out?

Ms. SULLIVAN. It's out now.

Mr. WOLF. Could we get a copy?

Ms. SULLIVAN. We started pilot testing it with a grant from O.A.P.P. last year. It is a third on substance abuse, a third on sexualty and a third on the cultural influence because the same things that affect one affect all three. And drinking is usually the entry of the three items.

Mr. WOLF. Could we get a copy of that textbook?

Ms. SULLIVAN. Yes.

Mr. WOLF. If you could, give it to the committee so we can take a look at it.

Ms. SULLIVAN. Certainly will.

Mr. WOLF. I want to thank the Chair for holding these hearings. I think they are very important. I don't think all wisdom, truth and knowledge lies on either side, and I think we are all searching.

But I think you make a very good point, Ms. Sullivan, whereby you ask for funding to be increased because although there may be people that don't think your approach works, not to try it is absolutely crazy.

I think that all these things ought to be looked at. So I personally believe, and if I have anything to say about it, I would certainly favor that increase in the funding for the abstinence approach.

Again, I thank the panel.

Chairwoman SCHROEDER. Congressman Riggs.

Mr. RIGGS. Thank you, Madam Chairwoman.

I guess—I will keep my questions a little bit briefer because I know we are in the lunch hour, and we have a lot of other things

to go on to. But I do have some specific questions, I think, of each of the panelists very quickly.

Ms. Zedosky, you talked about the comprehensive approach that you have implemented in West Virginia, and I wholeheartedly endorse that approach. I want to be clear in my mind that the school based component again, when does that begin? At what grade? And is that an articulated curriculum that continues there forward until the child leaves the school system, or the youth, I should say?

Ms. ZEDOSKY. Yes. We require health education in grades K through eight in West Virginia, and one full unit is required for high school graduation.

So our programs will begin early, there is a definite scope and sequence. And they will continue all the way throughout their schooling. With those other seven components of a comprehensive program wrapping around the health education component.

Mr. RIGGS. So it begins in the earliest grade in the eighth grade?

Ms. ZEDOSKY. No. It begins in kindergarten. Every grade from K through eight requires health education with one full unit in grades nine through 12 for high school graduation.

Mr. RIGGS. What does that mean?

Ms. ZEDOSKY. One year of health education. You know, you may have four units of English, two units of history, one unit of health education.

Mr. RIGGS. In the aggregate, grades nine through 12. I see. I wish you well.

I think the comprehensive approach is the right one. So it does begin in the earliest grades, in kindergarten.

Ms. ZEDOSKY. Actually, preschool, but we don't have overall responsibility for all of the preschool programs.

Mr. RIGGS. And this is a standard state mandated portion of the curriculum in West Virginia public schools?

Ms. ZEDOSKY. Yes, adopted by the West Virginia Board of Education.

Mr. RIGGS. So this is the State Board of Education?

Ms. ZEDOSKY. Yes.

Mr. RIGGS. Ms. McKee, congratulations.

Mr. MCKEE. Thank you.

Mr. RIGGS. I just wanted to get your views, maybe a little bit or slightly out of context that there is a lot of talk in this town about educational reform and educational excellence initiatives.

In my view, you know, it still comes down to underscoring the importance, indeed the critical role, that the individual classroom teacher plays. Also, involving the individual classroom teacher a certificated personnel, more involving them in school-based management, even discussions about curriculum.

Do you have an opinion on that?

Mr. MCKEE. Well, you have just elaborated upon the platform of my most popular speech. Most definitely, teachers and students make education happen.

And until we can get that across to law makers, that the most effective policy allows teachers and students to use their expertise in establishing curriculum and establishing how schools are run, I really don't feel we are going to have any true strides in educational reform. Luckily, we are moving in that direction.

I am very glad to see it happening. However, it is certainly not happening to the degree it needs to happen.

Mr. RIGGS. Have you had a chance to take a look at the President's proposed educational package?

Ms. MCKEE. Yes, I have.

Mr. RIGGS. Do you like what you see there?

Ms. MCKEE. I like the attention being given to education, because for many years there was not much given at all. The fact that the federal level is directing its attention towards education is very refreshing. That component, I am very excited about.

Mr. RIGGS. I am very interested in getting your ideas, if you would like to communicate them to me here at the committee or directly to my office, anything we can do to promote that involvement or to strengthen or in the case it sounds like the school district where you are currently employed, building a parent-teacher school compact. Because I think that is critically important.

Ms. MCKEE. Exactly. I appreciate that from you. I am most excited that the America 2000 strategy puts emphasis on community-based programs and comprehensive packaging.

Mr. RIGGS. Thank you.

Mrs. Wodraska, I am very concerned, more from the perspective of a parent of an adolescent, and a former law enforcement officer who used to come into contact with kids in what were, for them, very awkward and troublesome circumstances—I am very concerned about the students indicating that teen alcohol use is on the rise.

Do you have an observation there, and does the old nexus hold true about indicating at-risk—the incidences of soft drugs such as marijuana and more serious, even deviant behavior later on down the line?

Ms. WODRASKA. Several studies have indicated a precondition for harder drugs down the line, that they start here. That is almost a given in the prevention field.

In terms of increased alcohol use, our studies show those are decreasing with our program involvement. However——

Mr. RIGGS. May I ask you this, quickly, on that point, is that where you begin? I mean, how much do you focus on alcohol education, alcohol consumption prevention?

Ms. WODRASKA. Our program is considered primary prevention for the gateway drugs: alcohol, tobacco, and marijuana. But the perspective on alcohol is particularly disturbing. We are showing reductions. However, they are not as large as the reductions for cigarettes and marijuana. But if you look at the social situation as it is, for the last 20 or so years we have gotten so much education and community play about the risks of smoking. So in our society there aren't too many people who think smoking is a really neat thing to do. There aren't a great deal of people that would support it. Even our airline regulations, on domestic flights we don't smoke anymore.

Marijuana it is not a popular, socially acceptable thing to do. However, alcohol is such a socially acceptable thing to do for adults. When we celebrate, what do we do? We have alcohol. Our young people, they want to be adults. They gravitate toward alcohol.

We have situations in our community where the policeman will verify this, it is actually the parents or some of the adults in the community who will rent their motel room, buy the keg and say, as long as you stay here and you don't drive and drink and get into those other drugs, it is okay.

But what we did—our government action committee with the collaboration of the eight county prosecutors, put together a flyer, and what it is is, the adult legalities to condoning and providing alcohol for underage younsters. And it got tremendous play. The schools loved it. They sent it out around prom time. We disseminated it through the hotel-motel association, and the restaurant association. Amazing, the response we got from that. As long as our society views alcohol as a viable way to celebrate or relax, or all the reasons they give for using it, it sends a message to our youngsters, although it is illegal for their use, there is no such thing as a responsible use because it is illegal as well as a myraid of other reasons—it is not healthy. Our words and our actions don't always coordinate there, so the youngsters pick up, if you want to be adult, you drink.

If you look at the curve that research has provided for us, you see the curve for onset for early adolescence starts in the sixth or seventh grade. It goes up for marijuana and cigarettes, but the alcohol curve goes up off the chart. Almost invariably when I ask the question, adults will say, it is acceptable. It is a very acceptable part of our fabric.

So we have designed specific lessons in our curriculum to deal with alcohol, and we do try through our community interventions and our community awareness programs to bring the point that alcohol is a drug. It is not just that other thing.

Even accepting our adopted terminology—years ago you heard people say, alcohol and drugs. Now you hear them say, alcohol and other drugs. Simply by adding "and other," it focuses on the reality that alcohol is a drug. That has helped a great deal.

Mr. RIGGS. Thank you.

I should point out I represent the prime wine producing region in the United States, the Napa wine valleys, and my vintners are very concerned about what they perceive to be a neoprohibitionist movement in America.

I want to point out the very careful and well-thought-out explanation you just gave regarding the absolute reason and utmost necessity for having the school-based programs that impart some information about alcohol binges, and all the damage and destruction it can do in our lives.

I think if alcohol was banned, and I am not an advocate for that, there would be little for us to do. I can remember nights as a patrol officer going from one incident to the next and the common theme, if you will, that ran through every single one of those incidents was alcohol abuse, so I appreciate your perspective.

Mr. Duran, speaking of criminal justice, do you work closely with the criminal justice system? I think you mentioned, are criminal justice system referrals important to your program?...

Mr. DURAN. Of the youths involved in our program, a quarter of them come from the court system.

Mr. RIGGS. Obviously, those are indeed at-risk youths, but are those what we would call—we used to have a 601 section. You are familiar with that in California?

Mr. DURAN. Yes.

Mr. RIGGS. I believe it is the Welfare and Institution Code. Now, it is sort of a grey area institutionally speaking, but are those youths who have displayed some sort of at-risk behavior likely committing more serious offenses?

Mr. DURAN. Yes, those that are in for status offenses related to things that are illegal or criminal because of age, as well as other more serious offenses, mostly related to drugs and drug-related violence.

Mr. RIGGS. Are you coming up against the gang culture in your work? What does that overlay to all the other problems confronting the modern youth that we have been discussing here today?

Mr. DURAN. Sad to say, the gang phenomenon has reached the cities and towns in Massachusetts. What we are coming up against is an extremely more violent related phenomena not just confined to gangs. In a recent study, for example, among high school students, it was found in this study that about seven percent of them—these are about 2000 high school students outside of Boston—had been involved in a physically violent altercation in which one of the persons had to seek medical assistance.

We found among some of the youth in our program and the kids that they were working with as well, that incidents of sexual intercourse were also related to physical violence or threat of physical violence and coercion. So I think we are seeing now in our urban cities as well as in some of the more rural, outlying towns, that there is an increase in physical violence, there is an increase in gang and drug activity, there is a large increase in the school drop-out population and the persistence of poverty. And I think all of these converge into an at-risk status.

Mr. RIGGS. There continues to be a tremendous problem in California. You mentioned drop-outs, particularly severe in the Hispanic community? Any comments on that situation? I don't think we have made much headway in California in terms of reducing the number of high school drop-outs.

Mr. DURAN. I think certainly to answer that question in any competent manner we would need a lot more time than I could possibly have to answer it right now. I think one of the reasons we have not yet made headway about intervening into this problem is that we don't fully yet understand how to take what we know about the reasons people are dropping out and how to incorporate that into a school reform agenda.

More often than not, there are studies that are commissioned to examine the problem, and I would submit that probably where we should spend our resources is to take what we already know and examine how we can incorporate that into the reform measures, like parental involvement, like what is happening in the classroom and how we can support our teachers and respect them as professionals.

All of the adjunctive support services, all of the enrichment programs and after school programs, and all of the things that were present when I was going to school made for a very enriching

school experience, are really being sacrificed now at the altar of budget cuts and no new taxes.

Mr. RIGGS. You make a very, very good point. Not necessary with respect to budget cuts or taxes, because we could have a great political debate on that, but I think the dawning awareness on the part of those of us in policy-making positions in Government, is the desirability of front-loading the system, if you will, getting the most bang for the taxpayer buck by really putting the emphasis on early prevention, education.

I don't believe it has to be the nature of the beast that we always have to be reactive in nature and crisis oriented, as Government has traditionally been. The more we can do, obviously, with respect to prevention, and that is the really pronounced theme that has come out today, the better we are. And that is the wiser approach for stewardship of the taxpayer dollars. I appreciate that observation.

Ms. Sullivan, you have a very, very interesting program, one that I personally believe in and support and try to espouse, yet I wonder, and I don't want to be the devil's advocate to you with respect to these questions, it wouldn't be appropriate coming from our side, but I wonder how you can truly hope to be effective when our young people are bombarded with so much messages that would seem to promote, encourage sexual permissiveness? And I don't just mean the electronic media. I mean messages such as, for example, you are truly preaching abstinence now—a Republican candidate for the—or a candidate for the Republican nomination for President, a very upstanding man, a man who has made personal morality a very big part of his presidential platform and his livelihood, if you will. I am just thinking of him as an example. Here is a revelation down the road that his wife was pregnant and expecting at the time they got married. This is someone who certainly would espouse, maybe even preach the abstinence approach. Is it really practical that we can expand on your efforts, given all these mixed messages to young people, that abstinence is a viable choice, or is there something short of abstinence, increased responsibility, if you will, that ought to be the message that we really try to get out?

Ms. SULLIVAN. Well, I think the evidence that we have achieved over the last six years speaks for itself. We get 85 percent response from our students that are positive comments on the program. And we have still—we are a minute number, roughly about 25,000 students have been through it as compared to the whole Nation of students. However, that is a sizeable number.

And what I am pleading is, please talk to the teachers and the students who have been through this program, and your very reasons of talking about the avalanche of opposition is the reason why we must do this. Because we have shown over the last 20 years that we are going fast down the slippery slope. And we have to turn around or it is going to be a complete loss—that is a despairing attitude, to say there is nothing we can do. There is a lot we can do.

And I would like to say that the reason that we have some problems in schools today, and particularly maybe with the Latino community, is we have completely thrown out "directions" when it

comes particularly to sexuality in our schools. We have said, you can chose whatever field is okay for you. We throw in a bone and say, we all know abstinence is the one sure way, but, and the "but" is what is emphasized, and the "but" is what comes through when the emotions are high and the resistance is low on the Friday or Saturday night.

Let me communicate to you one of the greatest motivating speakers in the entire drug and alcohol scene today is a black, wonderful black mid-30-year-old, six foot seven, 330 pound "role model" who is so clear, and he brought out at our seminars in Chicago, he said, why do our youth join gangs? Because they are "directed." That is what appeals to these young people. They want "direction." And they are not getting it from the schools, and where are the parents?

Too many of those parents today are themselves products of the "nondirective" approach. That is why they can't control their kids. That is why they are not cooperating with the wonderful teachers and schools, because they were taught you just can't get those kinds to listen. So they have the idea that "my teenagers aren't going to listen." So they have abdicated their directive role. We must get back to that "direction," that is why the gangs are proliferating to the degree they are.

I think Milton Crier speaks eloquently for the black population. He ought to be put into everybody's school and city in this country. And I can guarantee you that in two to five years you would have a marked difference, but instead, no, he is not the one being supported by most of the federal dollars. It is those who say the despairing role, there is nothing you can do with these kids, make sure they have got their condom before they leave class this afternoon. That is not going to work.

Mr. RIGGS. I agree with you. And I wouldn't want you to think that I am one of the despairing cynical masses. But I want to get very clear on this point. I totally agree with you that young people are crying out in many, many instances, for clear direction. That includes teaching about morality and moral values.

Ms. SULLIVAN. You are right.

Mr. RIGGS. They obviously look to their parental influences, whoever is filling those role models, principally for their clear direction. But the one thing I want to be clear on is, when you talk about abstinence until marriage, do you mean no sexual intercourse? Is that really what it means?

Ms. SULLIVAN. Very definitely. Every reason to not engage in it as a teenager is applicable. I mean, call it monogamy, call it marriage, call it monogamous partner, that is what it is. That is the bottom line today. No adult isn't shattered by a broken physical union. We know that. Adults don't go in and out of physical relationships, that highly charged physical state, without emotional trauma, disease, and/or whatever else goes with it. To expect our adolescents to go in and out of that highly charged physical union is ludicrous. And we are, in fact, leaving them to that bad habit development of where there is nothing we can do about it.

Mr. RIGGS. So you are acknowledging that there will be sexual behavior and activity?

Ms. SULLIVAN. There always was and there always will be. Our job is to hold up an ideal, inform on what is right and wrong, healthy, unhealthy, good and bad. And we must give our youngsters those directions. Otherwise, we are going to see a catapult of the problems we have today, as I said, we all recognize. We cannot keep going in the same direction.

Mr. RIGGS. I understand. And I am willing to support you to the extent, as Governor Thompson did, or as you indicated Governor Thompson said in your written statement, that we ought to put at least as much emphasis on stressing abstinence as we do on anything else.

Unfortunately, we don't have any young people to testify before us. I think that would be a good idea.

Thank you, Madam Chair.

Chairwoman SCHROEDER. Thank you very much.

I want to say I am depressed. I am very depressed that we have allocated so few resources. The programs we are hearing about that work are just a little drop in the bucket, and I hear you saying you may lose your funding and you may not, and will the private sector keep coming forward.

Outside of West Virginia, I don't think there is another State that has got a comprehensive program.

Ms. ZEDOSKY. And we are not funded.

Chairwoman SCHROEDER. Exactly. That says to me, before we get all excited about this, this is great, we have programs, it is like throwing a bucket of water in the ocean and expecting it to rise.

I also think when you look at the statistics on our teens, they are devastating. If anyone thinks more teen parents is a good idea, they are going to love the way we are going. If you are going to double the number of teen pregnancies, and we did in the 1980s, we are on another real downhill trend.

I thought your West Virginia testimony was very good. You have got to deal with the whole range of families. It is wonderful to have families that are there which you can work with, but a Nation of dysfunctional families soon becomes a dysfunctional Nation. It is a little harder to figure out how we step in that direction.

I also have to say, as I listen to all of this, how saddened I am by the messages we see on TV. I have been very frustrated. We haven't taken on the alcohol problem. Sports are breaking out, what is it, beer and ball? I don't know how you would have ball games on the air if you didn't have beer. And it has been like a right-of-passage, a thing to adulthood.

And I think TV is such a—and sex on TV is unbelievable, too. You watch a few soap operas and you probably learn more than you would in any human sexuality case study.

And we have all of that bombarding our kids, and I think that is probably a much more pervasive influence, so it really is very dominant in the culture.

And so I find that very frustrating. I think what I hear from all of you is teens can be dealt with directly. And one of the things I worry a little bit about is, we want to give them very clear messages, yes. We want to state very clearly what the values are, yes.

But as I was listening to all of this, I was thinking how very easy it would be for a teen to take away the message that condoms

aren't 100 percent effective and you really shouldn't have sex, but if you have sex, it doesn't matter whether or not you use condoms. I don't think anybody would want that to be the bottom line message.

Yes, you are exactly correct, Mrs. Sullivan, that women have known for a long time, condoms don't prevent birth; they are the least effective of the birth control things. But we also know that in terms of disease, even if they are using other forms of birth control, they should still use the condom if they are engaging in behavior that we are concerned about because it is not monogamous.

As I hear some of this debate, I keep thinking how easy it would be for a teen to pick pieces of that out and justify their behavior and say we got it from these hearings. That would depress me to no end.

You want to make sure we are also sending a very clear message out at these hearings that while we don't approve of premarital sex, if they do it, they ought to be protected, and it has become apparent that it is a death-dealing disease which is certainly out there, and we can't guarantee even with all those things they could be totally protected, but it is better than running the risk and playing Russian roulette. That troubles me a lot.

Mrs. Zedosky, I wanted to ask you about the American School Health Association. They were saying that they supported the freedom to discuss other risky behaviors in programs that were funded by the drug-free schools.

One strain that I heard through the testimony was how correlated this risky behavior is appearing to be. Would you support what American School Health Association is saying? Do you feel all risky behavior should be tied in?

Ms. ZEDOSKY. Absolutely.

We have heard about the relationship of alcohol which reduces the ability to make good decisions and may lead them into premature sexual activity. I think that the programs are strongly interrelated. And, in addition, if you look at the load on the classroom teacher to teach the basics of reading and writing and math and then you also have a health education program of study, it must be an integrated, well-thought-out, comprehensive program. And every time you add a separate program to that, it makes it very difficult for the teacher to allocate the time. And so they may, in fact, teach a drug-free program as a health program, and the children do not then get information about nutrition and physical fitness and the other aspects that are also killing Americans prematurely.

Chairwoman SCHROEDER. I thought both of your points, and I know we all sit here as parents, but your comment on how hard it is for this Nation to say no, I mean, it is very hard for parents to say no, too. So if you grow up in a home where parents are hesitant about ever saying no, dealing with no and then we have all heard the game of "no means yes," where it was date rape or anything else, that really does cut across every single thing. It is an empowerment tool we really need to give them. So I am pleased to hear you say that.

I wanted to ask, too, was information that was specific to behavior of West Virginia teens from the CDC's youth risk behavior study helpful?

Ms. ZEDOSKY. Very helpful. Many times in a rural State where we have not had the incidences of crime and violence of a large city, because we don't have one, there is a belief that our students, therefore, are immune from the risk behaviors that they may see publicized in the media.

This demonstrated clearly that the rural population is as much at risk as any other group of teens in this country.

Chairwoman SCHROEDER. And I would like one more time for you to explain how this is not funded.

Ms. ZEDOSKY. It is a dream. It is a vision. We have the commitment, but in order to really do comprehensive health programming teachers need to be retrained. Evaluated, nationally certified curricula need to be purchased. There needs to be a commitment to change food service offerings, to increase physical education offerings, to increase access of health services, to increase numbers of school nurses and counselors. Those things are not funded.

And we feel that the prevention aspect of those programs would be very cost-effective down the road for a healthy population.

The reason the businessman in West Virginia has been so committed for so long is that he has recognized he cannot afford the workers' health care costs that come to business. And that has begun to be a theme among businessmen in our State.

You are right, we need healthier workers, and the only way to get them is to start young with children in promoting activities.

Ms. MCKEE. May I also comment on that? A thrust of mine has been educating the teachers and parents as to the role certain segments of our curriculum which very often are not thought of as health related can have in effecting health behaviors. The reading curriculum in particular, because I am a reading specialist. We overlook the fact that in rural areas, girls, in particular, have absolutely no outlet for interests or hobbies, at a point of feeling successful. And very often their sexuality becomes the only way, the only means by which they feel successful.

So that if I and other teachers, contribute to the child becoming a successful reader, very often that deters his sexual promiscuousness. This is something we very often don't address in any way, shape or form in our curricula.

Making children feel successful very often deters them from becoming sexually active. And as I said, that is something that very often is overlooked when we are addressing health issues and curriculum components that deal with sexuality.

Chairwoman SCHROEDER. Your sensitivity, I think, is why you are Teacher of the Year. If we could only clone that.

When you talk with young women, it cuts across everything. I was even going to ask Mr. Duran about that, too, with the Hispanic young girls. I think it is very, very difficult for them in that culture. There is this whole new phrase, the PBQ, the Personal Beauty Quotient that is enforced on women of all ages, and that when you really look at how the culture tells you if you are not beautiful and you are not popular, you are nothing, and we haven't

found ways for young women to be able to mark off success in other ways.

And we also see an incredible amount of incest in the home where young children even have trouble saying no to family members. In that kind of dysfunctional family, how do you operate in the outside society?

Denver, Colorado, has just been sent reeling by the ex-Miss America coming forward and talking about her experience growing up. It was very sobering to understand that, not being able to say no to a parent, obviously, and how you then relate to that.

So how do you handle the young women in the Hispanic culture? Do you have women counselors dealing with them, or is there a way to deal with the success that——

Mr. DURAN. Part of our emphasis is trying to talk about all of these behaviors, not just in terms of their negative consequences but in terms of their attraction and why teens behave in the way they do, so that we have a realistic context to talk with them about. Teens get high to feel good, and——

Chairwoman SCHROEDER. Or to escape.

Mr. DURAN. To escape from a situation that is intolerable and where they are not feeling as good as they could. Our youth specialists are both male and female. Our youth peer leaders' group is made half female and half male. And we do work with the groups together and then they separate into boys and girls groups, and they talk about different issues with their counselors.

Part of what we are finding out is precisely what Ms. McKee just said. Many of the young girls are having babies because it is the one area where there is a sense of self-efficacy, a sense of competence.

And in terms of different values, we have to allow for the fact that there are a range of different values from one culture to the next. And what we are struggling with in working with our parents is that the high value placed on babies in any culture is often times perceived as tacit approval of the pregnancy. And that is a very tough one for people to unpack and talk about.

Chairwoman SCHROEDER. I know there are new studies showing the infant mortality rate is lower among Hispanic women because the families intercede and get them proper prenatal care, but it also makes it more difficult to discourage. So it is very very hard. But that is very very true.

Ms. Sullivan, there have been all sorts of studies that have shown that giving people knowledge about family planning doesn't lead them to sexual behavior. You don't dispute those studies? Or do you?

Ms. SULLIVAN. Your statement—knowledge doesn't lead them to sexual behavior?

Chairwoman SCHROEDER. The one I cited in my opening statement, showing that young women who had discussions with their mother about what kind of family planning——

Ms. SULLIVAN. That statement bothered me because I thought you were contradicting yourself. Because I have got a rash of studies that I would be happy to send you that show quite the opposite. *Family Planning Perspectives* has numerous articles showing that

family planning education really has not worked. But their solution is more of the same.

Our suggestion is, let's try something different. And, in fact, one of the main things that ought to be developed with the new Administration education policy is choice in curriculum. Schools ought to offer a choice of what type of curriculum at all levels, be it reading, literature, health, a choice of the traditional roles versus the modern roles.

And I can't agree more than saying if we had programs in literacy that really taught them how to read they could read a lot of these things that would keep them out of trouble instead of concentrating on showing them how to put a condom on something.

Chairwoman SCHROEDER. But I don't think that is the concentration. I think the concentration that I would hope we could agree on is that if young people had the knowledge we are talking about here today—the condoms are not 100 percent effective birth control and 100 percent disease proof, but they are better than zero. And you still would prefer, if you want to be totally free and talk about where teenage pregnancy leads you, they clearly then have degrees of choices, but you make it very clear what is best.

Now, I don't think that that drives them out there. And I haven't seen anything that said that kind of knowledge then says to everyone, wow, let's go out——

I think I heard you say, some of the condom programs have said, here, they are. This is the answer to AIDS. Is that what you said?

Ms. SULLIVAN. Madam Chairman, I think you and I hear things quite differently. Your wrap-up from what this panel said is quite different from what I heard the panel say, to begin with.

But the bottom line is, how is the issue of condoms presented? Is it done in a positive, well, here is how to use it—let's show you how and where to get it—versus the presentation of—here is why you should not use it. Because it fails. Because it will not protect you. Because it does not stop the emotional trauma. And the manner in which it is presented is what will either work or not work.

And I urge you please not to keep giving the double message as the way you're describing it in your wrap-up, because——

Chairwoman SCHROEDER. Excuse me. You don't think there is any way people can handle both messages?

Ms. SULLIVAN. Youngsters, no. Adolescents cannot handle both messages. They are not mature enough, grown up enough, to do it. We have no——

Chairwoman SCHROEDER. May I ask the rest of the panel if they agree with that? Did I miss this whole thing? Mr. Duran?

Mr. DURAN. With all due respect, I think that we as adults, one of the problems that we are facing here, both in this discussion and in how this discussion translates itself into implementation, is that we give far too little credit to our adolescents. And so I think that there are a number of different messages that adolescents can hear, can believe and can translate into their own behavior.

And so I think part of what gets us into trouble is that we get involved in these either/or, black and white, right or wrong kinds of analyses. The fact of the matter is that kids respond best to things that are legitimate in their view, that come from people who they can trust, and kids, in particular, are asking for no bullshit

approaches. They want folks to come clean with them and talk with them about the reality. And they also want an opportunity to share what is their own perception of reality and how they see the world from their own perspective. And that often bumps up against the ideal world that many of us as adults would like to place in front of them and say, this is the best option for you.

The fact of the matter is, the kids, hearing all sorts of messages, like adults, are still engaged in risky behavior. If adults, with all that we might attribute to our maturity and to our wisdom and to our education and our ability to make decisions still buy cigarette packages that have health warnings and still smoke those cigarettes, how can we expect, how can we be truly honest with our kids and ourselves to think that simply giving them this information is going to stop behaviors that are part of the whole range of human sexuality, that are a part of each of us?

If we went around in this room, assuming we are all adults in this room, and ask how many of us are practicing safe sex, safer sex, how many of us are abstaining from things that are bad for us, I think it would be a very sobering experience to the extent that we would be honest in answering those questions.

Chairwoman SCHROEDER. That is—certainly, I would agree totally.

Does anybody else—I don't mean to misconstrue what I think is being said here. Does anyone else want to——

Ms. WODRASKA. I think it is extremely important to be consistent. I made reference to this in my testimony.

In terms of drug use, what we concentrate on, the no use message is definitely the one we have to give to our adolescents because there is no such thing as responsible use. Consistency is very important.

What else is very important is the social norms, the perceptions of social norms, whatever your society is for you, whether it be your culture as a teen or adult, the perceptions of those norms often indicate whether or not you are going to get involved in risky behavior.

As we have often thought that everyone—if you pick up the headlines, you think that every child of a certain age has experimented with something, and you are a child of that age and you want to belong the chances are you will try that, which our research indicates that every child of this age doesn't do it.

So we have to correct misperceptions of youngsters. Consistency is very very important. I don't think that information alone causes a change in behavior. It certainly has not in our case. It has to be combined with social skills approach. Information, although necessary, is not sufficient.

I think what I hear Mrs. Sullivan saying is that we have had a heavy dose of incorrect information on one side and maybe not a fair balance of reality, what should be as far as information about consequences. And then, of course, you know, the Lord himself gave us free will so we all have that. There are going to be choices made.

But as I said, information in itself doesn't necessarily change behavior. We learned that throughout our research with the substance abuse.

One thing I would like to say, though, and I think it is very important, recently in the prevention field you are reading more and more about resiliency, built-in resiliency in youngsters. Part of that is resistance skills. I think that is very important. When you are looking at building resiliency you need to look at the kids who are not engaging in risky behavior. So often we focus on the bad news.

Look at the numbers here. Let's look at the number of kids who go through the same kinds of influence, have the same types of pressures, what have they done to be able to resist? And I don't think enough of that focus has been there. I think we need to do that. I think that is a healthy focus for the prevention field. And there is much writing being done of that right now.

Chairwoman SCHROEDER. I think that is very true. One of the things we found that was very helpful in my state was to take young teens that were exchange students from other countries, and at the end of the year say, "okay, you come from countries where there is lower drug and alcohol abuse among kids, there is lower teen pregnancy rates. And on and on and on. You have lived in our culture for a year. What is the difference?" And it actually goes back to what you say, Mr. Duran, they all said there is a lot of bullshit in this country. They want no bullshit answers.

And in our country we were dealt with much more as adults. They told us the consequences of this. We don't think it is a good idea. But here we all tiptoed around things until we are so—they were not getting the clearest message they could.

I think if every community did that, the comparativeness of being an adolescent in another culture versus our culture would be helpful.

Ms. ZEDOSKY. The other point I would like to make is that in our programs we do say to students that it is very wrong to be sexually active as an adolescent. But it is our responsibility to educate children for the future. Formal education ends for many students at high school. They do not go on. They may learn to balance a checkbook in math class and never again do it in high school, but it is a skill they need later in life.

So it is my belief you equip them with skills they will need. The message is, you need this information to make good decisions as you move through life. Decisions about diet, decisions about exercise, decisions about sexual activity, decisions about birth control, access to health care providers, which one, where can I get this information, and this health service.

I think that is what we are trying to do in our school systems is provide them with standards, yes. And then information on which they can base lifetime decisions.

Chairwoman SCHROEDER. I think that is probably the way we should be going, and I thank, again, West Virginia for looking at that.

Let me just end by asking Dr. Kolbe, did you have anything you wanted to add—are you going to get for us the latest studies on condoms?

Dr. KOLBE. I will make sure that the CDC provides that information for you.

Chairwoman SCHROEDER. I think that would be very helpful if we could get it within the next two weeks. I think it is important to have the record whole.

Mr. DURAN. I am sensing that you are approaching closing the session, and I would kick myself for not having said this. This is more by way of editorializing than suggesting Federal policy. I don't know whether I am just reacting to the artwork in this room, but I think it was Mr. Johnson earlier who said that we have to premise all of our discussion today on the fact that there wouldn't be any new resources, and the likelihood of allocating any more Federal resources to this problem is nil.

And so I would ask this question simply for the record and for this select committee. Why are you not seeing this as a national defense issue? I went to school and college with the benefit of national defense student loans. Those came into being by dint of the fact that the Russians put the Sputnik up in the air. If we can't consider public health, particularly the health of our adolescents who are the caretakers of our future, as a national defense issue, then I think we not only have dysfunction among our families and within our communities but there is something dysfunctional going on in the Federal spending priorities of this country.

Chairwoman SCHROEDER. I think that is a very good note to end on, and you picked the symbolism for why we had it in this room. As I pointed out, we have got money for all this wonderful art, but we don't have money for adolescents.

It is interesting the kind of things we do fund. And part of it is because it is tricky, as you saw from the tension that can arise when you start discussion—parents all want to be able to handle this themselves, and then when you ask someone when is the last time they had a good conversation with their children on these issues, very often you find they have never had one and are afraid to.

When there is that much tension I think the Federal Government has been very hesitant to go in there. But I think we are all reaching the point that it is a national defense issue. More countries fall from within than without. A nation of dysfunctional families becomes dysfunctional.

So the Chair is very pro allocating a whole lot more resources in this area, any way we can. And, as I said, that is why I was very depressed when I found how hard it is to find these programs. There are a few out there, that is the good news. The bad news is there are very few and there are thousands and millions of children who are not being taken care of.

Let me thank you all for your appearance. We will continue this hearing tomorrow. With that, this hearing is adjourned.

[Whereupon, at 1:15 p.m., the committee adjourned.]

[Material submitted for inclusion in the record follows.]

PREPARED STATEMENT OF HON. DAVE CAMP, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Madam Chair, thank you very much for holding this hearing today. I am pleased to see such an illustrious panel and so many people here today to discuss how we can keep our kids safe. It is so important to families everywhere around the country, in both urban and rural areas, to have the capability, and the opportunity to protect our children from harm.

Children today face hardships that most of us never had to experience. Teens are exposed to alcohol, cocaine, crack, and other drugs much earlier in their lives than ever before. We cannot just stand by and watch our children suffer the hardships most of us only heard about. We need to take action to protect their lives, and their futures.

Today, we have the opportunity to protect them. Let's work together as lawmakers, parents, teachers, and providers to find the best solutions to these problems facing our youth. They are the next generation. Their future depends on us.

PREPARED STATEMENT OF HON. CLYDE HOLLOWAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

The myths about teen sex, "safe sex" and now "safer sex," unfortunately have spread as wide as teen pregnancy and AIDS and hundreds of thousands of teens are paying dearly. The hearts of today's teens are not hungering for better birth control devices, more condoms, more "safe sex" classes, or school based health clinics—what teens hunger for is *guidance, direction,* and *standards.* Yet, the response to this deep hunger has too often been to throw up our hands, throw in the towel and throw out the condoms to our kids. Of course this is done with much hand wringing by well-intentioned parents and "experts" who consider the "we don't want you to have sex but if you do. . . ." method of sex education as the only "realistic" way to go.

In an area of their lives where children most need adult direction, we can't stand by and do nothing. The messages that kids get today are anything but neutral. Most everything they hear from their school teacher to MTV tells them that sex is a matter of choice and not a matter of values. We cannot be neutral when our children are in the war zone.

Neutrality is particularly absurd when we know that the methods of the "safe sex" crowd don't work. Studies by people and institutions who favor these methods have shown they have failed. Study after study by the Alan Guttmacher Institute (the research arm of Planned Parenthood) show all that is gained from sex education and school based health clinics is more knowledge about sex, not more responsible behavior. In fact their own studies show that many of these programs have increased the rates of sexual activity of those who have participated. This is not surprising when we consider the position of Planned Parenthood President, Faye Wattleton: "We are not going to be an organization promoting celibacy or chastity. Our concern is not to convey "shoulds" and "should nots." Well I disagree. I think we should promote chestity and celibacy for our teens.

After two decades of ignoring moral responsibility and millions of dollars spent on family planning for adolescents what do we have to show for it? In 1988 almost one out of every five sexually experienced unmarried teens became pregnant. One out of five! And for those who practice "safe sex" the record is no better: Among unmarried women under 20 using condoms, a study in *Family Planning Perspectives* found that 13.3% of white women became pregnant and 22.3% of nonwhite women become pregnant in the first year of use. As Dr. Robert Noble, professor of medicine at the University of Kentucky College of Medicine recently wrote in *Newsweek: "Condoms aren't going to make a dent in the sexual epidemics that we are facing* . . . Unmarried people shouldn't be having sex. Few people have the courage to say this publicly. In the context of our culture, they sound like cranks. Doctors can't fix most of the things you can catch out there. There's no cure for AIDS . . . There is no safe sex . . . If the condom breaks, you may die."

But the good news is that all that is really required is that we change our minds—the main obstacle to children's well-being is a huge mistake in the judgement that it may be okay for children to have sex. This is clearly a mistake.

Why do we oppose letting children be children? We speak of "children having children" when 14 year olds get pregnant, but when this same 14 year old is having sex, she is called "a young adult." If children are having children, it is obviously because children first had sex and it is too often because nobody told them it was the wrong thing to do. It is not that abstinence has been tried and found wanting, it hasn't been tried because it's viewed as too hard to do.

I would like to share a challenge with my colleagues first made by columnist, William Raspberry: "Are we prepared to concede that they [teens] will do things we know are not in their best interest? Well some of us will insist . . . that when it comes to sex, the only acceptable instruction adults can offer adolescents is "Don't."

PREPARED STATEMENT OF GORDON M. AMBACH, EXECUTIVE DIRECTOR, COUNCIL OF CHIEF STATE SCHOOL OFFICERS (CCSSO), WASHINGTON, DC

Madame Chairwoman, members of the Select Committee, I appreciate the opportunity to submit for the record a short statement on behalf of the Council of Chief State School Officers (CCSSO). Also attached is a Chapter from our publication, Beyond the Health Room, and recent testimony on collaborative services from the Joining Forces Project sponsored by CCSSO and American Public Welfare Association.

The health as well as the education of all students is a major concern of every chief state school officer. Because poor health leads to poor learning, school health programs today must go beyond simply providing a health room and a part-time nurse, or offering a semester of health education. The health problems of the 1990s are serious and include HIV infection and AIDS. Finding solutions requires comprehensive programs that work closely with other agencies as well as families.

Key federal action to reduce high-risk behavior among school-age children will be prevention efforts directed at specific behaviors, the provision of adequate social and health services in our nation's schools, and increased federal investments to improve educational performance and opportunity.

HIV EDUCATION AND PREVENTION

CCSSO began the HIV Prevention Education Project in 1987. Funded by a cooperative agreement with the Centers for Disease Control, this project assists chief state school officers and state education agencies by providing programs and fostering collaborative efforts to address today's school health issues, including HIV infection and AIDS.

Beyond the Health Room provides a solid base for discussing the role of schools in improving the health of children and youth. The four chapters provide essential information about school health programs and the health status of young people in this country. Chapter III, which we submit for the record, takes a close look at the three essential building blocks of a comprehensive school health program (instruction, environment, and service) and shows how each plays an important role in meeting the health and education needs of all students.

COORDINATION OF SERVICES

A key part of providing comprehensive school health services is connecting existing and new social and health services by: strengthening the ability of communities to take on a collaborative agenda; assuring that state and federal barriers to joint action are removed; and assuring that funding streams and structures support and incorporate cross-sector action.

The federal government should use financing strategies to foster institutionalization of joint endeavors -- first, by assuring that new funding in this arena is structured in a way that encourages and facilitates connection with existing funding streams and mechanisms; and second, by loosening the narrowly categorical nature of funding as communities identify cross-cutting approaches that promise to be more effective, and in all likelihood more cost-efficient, in serving children and families.

A good example of the latter might be to allow Medicaid reimbursement for preventive health services provided to all students in a school, not just those individually determined eligible, when the school qualifies for a Chapter 1 schoolwide project because the majority of its students are low-income.

TOBACCO USE PREVENTION

The Council encourages the House to move legislation on tobacco use prevention which Senator Kennedy and 19 of his colleagues have introduced in the Senate (S. 1086). In order to further tobacco use prevention efforts in the schools, S. 1088 establishes a grant program to schools for effective prevention assistance; amends the Drug Free Schools and Communities Act of 1986 to allow funds to be used for tobacco use prevention as well as illicit drug and alcohol use prevention; and provides incentives for state education agencies to create smoke-free elementary and secondary school buildings, grounds and school buses.

ATTACHMENT: TESTIMONY OF JANET E. LEVY, DIRECTOR, JOINING FORCES, WASHINGTON, DC, BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES OF THE UNITED STATES, MAY 8, 1991

Mr. Chairman, members of the Committee, I appreciate this opportunity to testify about the potential for cross-system collaboration to support achievement of the national goals for education and to help assure success for all children and families, including those now at risk of long-term disadvantage.

I am Janet Levy, Director of **Joining Forces**, a national effort to promote collaboration which is co-sponsored by the Council of Chief State School Officers and the American Public Welfare Association. These two organizations represent the top state officials in education and human services. Their co-sponsorship of **Joining Forces** reflects the concern and commitment of these state leaders to the well-being of our nation's children, and their belief that that well-being can be assured most effectively through the combined efforts of the various systems serving children and families.

For almost three years, **Joining Forces** has worked to expand interest in and support the implementation of greater collaboration between schools and human service agencies. As part of that work, we have traveled extensively throughout the country and have talked with hundreds of policymakers and practitioners who are reaching beyond their traditional professional boundaries to make connections that count. Our program files contain almost 1,000 examples of the creative partnerships being formed among institutions which are very different, yet which are nonetheless committed to a common goal -- the well-being and success of those they jointly serve.

The challenge now before this Committee, states and communities throughout the nation is to make the collaboration embodied in these inspiring examples the norm rather than the exception. Much of the responsibility for meeting that challenge rests with individual communities. But there are three critical ways in which the federal government and the states must help:

1) Strengthen the capacity of communities to take on a collaborative agenda;

2) Assure that state and federal barriers to joint action are removed; and

3) Assure that mainstream structures and funding streams support and incorporate cross-sector action.

Conditions Which Compel Action

We are all familiar with the haunting statistics which paint a bleak picture of what is happening to America's children. Of the children entering school in 1988, one in four was born into poverty, half a million were born to teenage parents, over half will at some point live with only one parent, in households that are prone to poverty and stress. Two million children a year are reported abused and neglected. Families with children now constitute a third of those who are homeless.

Deeply troubling in themselves, these conditions are of even greater concern in light of a growing body of research which makes clear the correlations between social and economic risk factors, educational achievement, and long-term well-being. The same conditions that propel a family to seek help from a human service agency are fundamentally related to a child's performance in school. Children who are ill-prepared when they begin school, who are hungry or in poor health, who are abused or neglected, whose chaotic home life provides little nurturance or support for achievement, who miss school to care for a younger sibling or to help provide income for the family -- these are children whose success in school and, eventually, in the workforce is truly in jeopardy.

Although none of these risk factors makes school failure inevitable -- many of those "at risk" do succeed -- such hardships create formidable barriers for millions of youngsters. If present patterns hold, at least twenty-five percent of America's young people will not graduate from high school; those who live in urban areas or who come from low-income families face even more dire prospects. In an economy that demands ever-increasing knowledge and skills to command a place in the job market, that future is no future at all.

A Moment of Opportunity

Policymakers, administrators and line staff throughout education and human services are well aware of the growing chasm between the enormous and complex problems of today and what the systems as presently configured are able to do to help. Schools alone cannot compensate for the disadvantage created by troubled homes and troubled communities. Welfare and social services alone cannot promise a hopeful future to those who lack abilities demanded by the job market.

The gap between what exists and what is needed is driving promising reform in virtually all sectors. An important first step in welfare reform was taken two and a half years ago, when the Family Support Act of 1988 (P.L. 100-485) fundamentally redefined the mission of our nation's public welfare system, committing federal, state and local efforts to strengthening families and helping them move toward self-sufficiency. Today, our attention is on the national goals for education, which make at least as challenging a commitment to the success of children and adults.

These individual efforts at systemic reform are terribly important. But it is the convergence of those efforts -- with their remarkably similar and interdependent objectives -- that makes this a particularly opportune time to nurture the linkages which can result in a seamless web of support for our children and families.

What's Already Happening

The hundreds of examples of collaborative action in **Joining Forces'** files are testimony and tribute to the way states and communities are beginning to form these critical linkages. The examples are wide-ranging: one school and a single service provider helping a targeted group of youngsters; the joint commitment of the school system and all the major agencies in a community to find more effective ways of serving families; the establishment in statute of a mandate for school-based service centers as part of statewide education reform.

Because this morning's next panel will give you an opportunity to hear directly from those who are running programs and initiatives like these, I will not try to describe in detail what is happening. But it is worth noting in at least broad terms some of the significant achievements. The ability to detect early signs of trouble and make an effective connection to services means that children and families are getting the help needed to stay on track, before a small problem becomes a crisis. As communities come to understand the unmet needs of their citizens and the previously untapped potential of the various systems, new kinds of services are being created. And, perhaps most important, the groundwork is being laid for a far more extensive, comprehensive and well-integrated set of supports for children and families.

What Is Needed From the Federal Government

A common thread in almost all the successful endeavors is that they are community-based -- either emerging directly from action by the community itself or resulting from a state-initiated process that allowed local flexibility in implementation and fostered local ownership of the results.

If collaboration must be essentially a locally based process -- building on the unique needs, strengths, and opportunities of individual communities -- is there a role for other levels of government? Absolutely. In fact, to move beyond a set of isolated, albeit shining examples, the signals must be set and collaborative activity supported and reinforced at every level.

Three types of state and federal action will be particularly important to stimulate and ensure the staying power of community-level collaboration:

1) Strengthen the capacity of communities to take on a collaborative agenda;

2) Assure that state and federal barriers to joint action are removed; and

3) Assure that mainstream structures and funding streams support and incorporate cross-sector action.

Strengthen Community Capacity

Even those who have been most successful at it will tell you that building bridges between schools and outside service agencies is an extraordinarily difficult process, which often must be aided by resources beyond the community itself. Technical assistance and training will be vital if we are to realize a comprehensive and long-lasting collaborative agenda.

This is especially true with respect to our most distressed communities. When the state of New Jersey used a request-for-proposal process to issue grants to local communities for the School-Based Youth Service Initiative, the city of Newark had great difficulty marshaling its resources to submit a plan that could compete against others. As is so often the case, those who needed assistance the most had the least capacity to organize themselves to get it; grant-writing skills are not an equitably distributed commodity. It was only because a commitment and machinery existed at the state level to provide help to the community in developing its plan that students in Newark, like those in less disadvantaged areas, now are benefiting from readily accessible services.

Conditions need not be so severe for state agencies to play a valuable role in getting community-level collaboration started and in helping it proceed more smoothly. Ohio, for example, undertook welfare reform planning for teen parents first by creating a state-level interagency team, whose members developed a mutual understanding of each systems' constraints and capabilities, as well as a shared understanding of the young mothers' needs. The state-level team then organized a working conference and subsequent process that helped local teams develop a similar understanding and begin design of detailed local plans for serving teens and their children.

The reality, unfortunately, is that our workforce is replete with professionals who have been well trained in their own fields, but who have been given little if any insight to how complementary systems function and can be engaged in a common effort. A significant part of capacity-building in the area of collaboration will be providing the training that can bridge that gap and enable those in the various sectors to recognize and pursue opportunities for joint action.

Relatively small "glue money" grants have also proven to be valuable incentives to prompt collaboration and underwrite some of the costs of getting a collaborative effort underway. The Illinois Urban Partnership Grant Program awards such grants to school principals, backing the grants up with training for the principals and with a dissemination network that brings promising collaborative programs to the attention of non-grantee schools and school districts in the state.

These experiences strongly suggest the importance of including a capacity-building component in any federal effort to stimulate collaborative action, preferably by reinforcing states' ability to support their local communities. Moreover, much as Illinois is doing within the state, the federal government is well positioned to assure that a national-level dissemination capability is in place, so that those preparing to take action can draw on the experiences of promising efforts throughout the country.

Assure That Barriers to Joint Action Are Removed

All of our instincts tell us that the statutory and regulatory barriers to joint action are significant, and when one listens to conversations about collaboration, calls for "waivers" and "cutting the red tape" are often heard. At this point, however, experience has not quite caught up with instinct; thus far relatively few specific barriers have been identified. Certainly, this is not to suggest that there are none, only that collaborative efforts are too new to have encountered most of them.

But because we know that, as cross-sector collaboration expands and matures, the barriers will emerge, there is a need to have in place a commitment and institutional capacity to resolve quickly problems which threaten legitimate, desirable action on behalf of children and families. The terrain of collaboration is littered with plenty of land mines like "turfism" that are beyond the purview of the federal government and states; we can at least assure that those which can be tackled are defused before community momentum is lost.

The recent emergence and resolution of a problem with implementation of the Family Support Act offers a good case in point. The Act makes clear that education is central to welfare recipients' ability to achieve financial independence and, by implication, encourages the education system to be a partner in promoting family self-sufficiency. Yet, federal regulations appeared to require that education agency funds dedicated to serving welfare recipients would have to be transferred from education to the welfare agency and then contracted back to education to qualify for federal match -- a contorted process that belied the image of full partnership and posed a potential barrier to the participation of education agencies.

Fortunately, this was a good example of how barriers can be dealt with effectively. Once states were able to demonstrate to the Department of Health and Human Services that their purposes were legitimate and that accountability could be maintained, an accomodation was found that allowed funds to be used as state match in the JOBS program and yet remain with and be expended directly by education. That's the kind of responsiveness that must be ensured, especially as the federal government itself encourages the formation of strong bonds across sectors.

Assure That Mainstream Structures and Funding Streams Support Collaboration

If collaboration is to be a sustained, integral part of the way we help assure success for children and families, it must be woven deeply into the fabric of our

institutions and supported in every piece of legislation and every funding stream which affects those institutions.

San Diego's multi-service center on the Hamilton Elementary School campus, which you will hear about in more detail shortly, is an excellent example of how collaborative endeavors can be well integrated with the school itself. All families will visit the center, because that is where they will register for school. In that way, the staff will have a chance to assess the needs of every family and offer appropriate services or supports. Moreover, in the minds of the families, the center will not be just a place where "bad kids" get sent when there's a problem -- going to the center will be as natural as going to school.

Perhaps the most important way to assure widespread replication and long-term survival of these efforts is to connect them with mainstream, institutionalized funding sources. This was a motivation behind Kentucky's analysis of the potential for supplementing state funds appropriated for the creation of school-based Family Resource and Youth Service Centers with Title XIX (Medicaid), Title IV-F (JOBS), and Title IV-E (Child Welfare) funds. The analysis, conducted by the Center for the Study of Social Policy, suggested that the state could gain between $13 and $16 million in federal revenue to expand programming for Kentucky's children and families, simply by making more effective use of currently permissible options under federal entitlement programs.

In the short term, the states and localities must take the lead in connecting collaborative approaches with existing funding sources. But in the longer term, the federal government too can use financing strategies to foster institutionalization of joint endeavors -- first, by assuring that new funding in this arena is structured in a way that encourages and facilitates connection with existing funding streams and mechanisms; and second, by loosening the narrowly categorical nature of funding as communities identify cross-cutting approaches that promise to more effective, and in all likelihood more cost-efficient, in serving children and families.

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Cross-sector collaboration is just one among many strategies that must be pursued to meet the challenge of the national goals, but it is an especially important one because of the promise it holds for helping to assure that all children succeed. I commend this Committee for its readiness to take action to advance a collaborative agenda, and will be happy to answer questions or provide additional information that can assist you in your deliberations.

Thank you.

Beyond the Health Room

BEST COPY AVAILABLE

School systems are not responsible
for meeting every need of their students.
But where the need directly affects learning,
the school must meet the challenge.
So it is with health.

Carnegie Council on Adolescent Development, 1989

III

UNDERSTANDING THE CHARACTERISTICS & COMPONENTS OF COMPREHENSIVE SCHOOL HEALTH PROGRAMS

Children and youth, especially those at risk, have an increasing need for thorough health instruction, accessible and affordable health services, and a school environment that is conducive to learning.

The three basic building blocks of a comprehensive school health program are instruction, health services, and a healthy school environment. To be effective, these components must be coordinated so that they complement and reinforce one another.

This chapter looks at these three vital components of school health programs, the importance of coordinating school programs with other community services, how school health programs can be assessed, and what we know about reaching disadvantaged children and youth.

INSTRUCTION

WHAT IS MEANT BY COMPREHENSIVE HEALTH INSTRUCTION?

Comprehensive health instruction provides students with the basic information they need to make choices about their health.

One of the most important things a comprehensive school health program can do is empower children and youth to be responsible for their own health wherever possible. For many Americans, school is the only place where they get the information they need to make good health decisions. Those who do not learn important health lessons in school may never learn them.

Most schools offer some health instruction, although it is often minimal. Many school systems teach health at only one grade level. In fact, 22 percent—or about eight million public school students—receive either no health instruction or instruction during only one academic year. (Metropolitan Life Foundation, 1988)

WHAT TOPICS SHOULD BE COVERED?

Comprehensive health instruction typically covers the following topics:

- Preventing unintentional injuries
- Safety, including first aid
- Health care resources—knowing what is available and how to be a good consumer of health services
- Environmental health
- Family life education, including information about family dynamics, building relationships, child abuse, choices about relationships, family planning, parenting skills, sex education, sexually transmitted diseases, HIV infection, and AIDS
- Nutrition, including balanced diets, food preparation, reading food labels, and

differences in nutritional needs for pregnant women

- Dental health
- Disease prevention, including heart disease, stroke, diabetes, and cancer
- Tobacco, alcohol, and other substance abuse prevention
- Mental and emotional health, including building self-esteem, coping with stress, and communication skills
- Physical education—fitness and exercise.

HOW EARLY SHOULD HEALTH INSTRUCTION BEGIN?

As soon as a student is enrolled. Instruction in health is appropriate for all grade levels. Instruction should begin in kindergarten or before and continue incrementally through grade twelve.

Even very young children can learn safety measures (how to cross the street or dial 911), nutrition (that fruits and vegetables are good for them, and sugary snacks are not), disease prevention (what germs are), drug abuse prevention (what drinks contain alcohol, what alcohol can do to a person, why smoking is harmful), and many other health lessons.

HOW OFTEN SHOULD HEALTH BE TAUGHT?

The more often health issues are covered, the more effect the instruction has on students. A three-year study of 30,000 4th through 7th graders found both knowledge and, more importantly, positive behaviors increased as students had more health instruction. Fifty or more classroom hours each year—about an hour and a half a week—produced significant attitudinal changes by these students. (Connell et al., 1985)

SHOULD HEALTH BE A SEPARATE COURSE OR INTEGRATED THROUGHOUT?

Both may be needed, depending on content and grade level. Most health experts recommend that health be a separate subject at both the junior and senior high school levels. Also, because knowledge of health provides a vital foundation for making healthy

life choices, they recommend requiring instruction in health for high school graduation.

Health can be integrated into other courses at all grade levels. Health issues can be used to teach writing and research skills, and in biology (growth and development), home economics (nutrition), history (disease control), and social studies (foods and health practices in other lands). Writing and research assignments can address preventive medicine, stress reduction, or disease control.

Health can be taught effectively in short, frequent sessions in the early grades. Effective learning more likely comes from something simple said often, demonstrated in various ways, and made relevant to students' lives, rather than from a long lecture once a year.

HOW SHOULD HEALTH BE TAUGHT?

Health should be taught by example. Conflicting messages, such as being told not to smoke and then seeing a teacher light a cigarette just outside the school door, can negate many hours of classroom instruction. Worse, it erodes trust and credibility.

Health should be taught with an understanding of the importance of peer pressure and should instill confidence in young people so that they are strong enough to resist it. Good curricula that include role plays and practice rejecting temptations to engage in risky behavior can help build this strength.

Most of all, health should be taught in an empowering way. Although some health problems, such as congenital diseases, are beyond our control, students need to see how much control they *do* have. They need to understand the connections between what they eat and how well their minds and bodies function, as well as the relationship between exercise, strength, and stamina. On a larger scale, they must see the cause and effect of their behavior and take responsibility for how they affect others: drunk driving, for instance, puts many lives in jeopardy.

WHO TEACHES HEALTH?

Health lessons are taught by everyone—through example as well as curricula. All school staff—not just teachers—should have the opportunity to attend inservice training so that their daily interactions with students reinforce health lessons taught in the classroom.

At the primary school level, teachers and staff must have training on how to integrate health instruction into all aspects of the school program. Very few elementary school teachers have training in health, and most states do not require teachers to take any courses in health instruction. In fact, elementary certification in health is available in only 11 states. Even in states with certification standards, certified teachers are not always the ones who teach health. (Lohrmann et al., 1987) Clearly, inservice training is much needed at the elementary school level.

At the secondary level, most health courses are taught by staff with little or no formal training in health. (Lohrmann et al., 1987) This must change. Health instruction in secondary schools should be taught by well-trained health teachers.

SERVICES

WHAT IS MEANT BY COMPREHENSIVE SCHOOL HEALTH SERVICES?

A comprehensive school health program provides students with services—or access to services—they need. For some students, school is the only place where they get basic health information and services. At a minimum, schools can tap into available health resources in the community.

Many people still think of school health services as a health room with a nurse who puts a Band-Aid on a cut. This image is far from reality. First, the health problems of today's students are complex. Second, few schools actually have a nurse on-site. More often, a nurse visits a school for only a few hours each week.

Health services offered in a school setting or coordinated with schools are increasingly important. The growing health needs of children and youth, the rising costs of health care, and the long working hours of many parents make it difficult for children to get needed medical attention. In addition, the mainstreaming of children with disabilities into regular classrooms brings its own set of health issues.

WHAT SERVICES SHOULD SCHOOLS OFFER?

That depends on the needs of students and the degree to which these needs are met elsewhere in the community. All schools should provide routine first aid and care for students with chronic and episodic illnesses, operate vision and hearing screenings, keep up-to-date health assessment and immunization records, and make referrals for further care. (Pine, 1985)

Many schools go beyond this minimum, providing a range of health-related services to promote good health, prevent unhealthy behaviors, and identify possible health problems.

For example, schools can take the lead in promoting good health and wellness, encouraging healthy behaviors, and teaching new skills. This can include operating facilities and services to encourage good nutrition and exercise, providing help with stress reduction, and running staff and student wellness programs.

Schools can also help prevent health problems by raising staff and student awareness of health-related issues and problems by sponsoring such activities as:

- Campaigns to prevent substance abuse
- Sessions on resisting peer pressure
- Prenatal classes
- Sessions on preventing child abuse and neglect

- Sessions on family planning, well-baby care, and "date rape."

Finally, schools can identify health problems that already exist and help students and their families take the first step toward resolving the problems. Identification procedures can include:

- Maintaining immunization records
- Screening for vision, hearing, developmental growth delays, lead poisoning, hypertension, scoliosis, and dental problems.

At a maximum, schools can provide comprehensive health services through school-based health clinics.

ARE SCHOOL-BASED CLINICS FOR EVERYONE?

No. Each community has its own set of needs and resources. The services a school provides should be decided by taking many factors into account: the health needs of students, local demographics, the availability and affordability of health resources in the community, and the extent to which young people actually use existing health services.

School-based health clinics serve a wide range of needs. They provide athletics physicals, screenings, immunizations, general health assessments, birth control and family planning services, and substance abuse programs.

Clinics can be funded by the school system or health department—or they can be extensions of local hospitals or public or private health agencies, where schools provide the space while other agencies cover the cost. In other cases, the clinics are school *linked*, rather than school *based*—that is, located off school grounds but operated in cooperation with the school.

Not every community can benefit from a school-based or school-linked clinic, but many clinics have had great success. At

some clinics, up to 75 percent of the students use clinic services at least once each year. Clinics help prevent unintended pregnancies: many report a 40 to 50 percent drop in the rate of births to teenagers after opening. (Lovick and Wesson, 1986) Clinics report that, on average, over half of the students using them have no other source of primary health care. (Lovick and Stern, 1988)

Do Schools Have to Provide All These Services?

No. Many communities already have high-quality, affordable health care resources that meet the needs of children. Schools can take the lead in coordinating health services so that they are easily accessible to school-aged children and their parents. Schools also can encourage children to use community health resources.

Where these resources do not exist in the community, where they are not readily accessible to students, or where it is clear that students are not using them, schools should consider providing needed health services in or near the school building. This may mean building new partnerships with community health care agencies or tapping nontraditional funding sources such as private foundations or state and federal health programs.

Do School Nurses Already Take Care of All This?

No, almost never. It is a myth that every school has a nurse. Many do not, and others have a visit from a nurse only half a day (or less) each week.

In some school districts, the school nurse is the sole health professional. In others, the nurse works with part-time staff, such as physicians, other nurses, or paraprofessionals. In other cases, the services provided by the school nurse are supplemented with contracted services, such as medical diagnoses, laboratory testing, and social services.

A good nurse-to-student ratio is 1:750, or, in schools with disabled students who are mainstreamed, 1:225, according to the

National Association of School Nurses. (Pine, 1985) In reality, many districts have one nurse for 2,000 to 3,000 students, a ratio that makes providing needed services difficult at best. (Kolbe et al., 1986) For many schools, an increased investment in a well-prepared school nurse would reap substantial health benefits for students and the community alike.

WHAT IS A WELL-PREPARED SCHOOL NURSE?

A well-prepared school nurse has a baccalaureate degree in nursing as well as special training to work in the school setting. (American Academy of Pediatrics, 1987) Most nurses are trained to work in hospitals, not schools, and need additional training to work effectively in the community-school environment. A well-prepared school nurse also is knowledgeable about and sensitive to multicultural issues, whether through formal course work, inservice training, or her or his own experience.

The American Nurses' Association includes a wide range of services in the standards for school nursing, including establishing and maintaining a comprehensive school health program, developing individualized health plans, collaborating with other professionals, promoting optimal wellness through health education, and working with others in the community to assure the broad continuum of health services. (American Nurses' Association, 1983)

ENVIRONMENT

A healthy school environment includes a psychological climate conducive to learning and a safe physical surrounding. Many factors contribute to the overall school environment. These can be thought of in three categories: physical, social, and emotional.

THE PHYSICAL ENVIRONMENT

Most school administrators already work to ensure a safe physical environment for their students and staff. They check that the

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structure of the building is sound, health and fire codes are adhered to, and crossing guards are posted on street corners.

Schools can facilitate a healthful physical environment by:

- Following building codes and inspecting lighting and ventilation systems
- Checking for and correcting any problems with asbestos or radon contamination, as well as lead in the school's paint and water
- Having a strong school safety program for buildings and playgrounds
- Having infection-control policies and procedures
- Providing sanitary and nutritional food services.

However, only 33 states mandate annual kitchen and cafeteria inspections. Fewer than a third of the states require inspections of chemical labs, gyms, or playgrounds. Many schools have problems with overcrowding, poor heating and ventilation, and such contaminants as asbestos and lead. (Kolbe et al., 1986)

Food programs contribute to a healthful school environment when the food served is well-balanced and nutritionally sound. Vending machines can offer healthy snacks and beverages, such as fresh fruit and fruit juices.

Many schools have become healthier places by becoming "smoke-free." Some schools offer smoking cessation programs as well as information about the harmful health effects of tobacco use, often in cooperation with a local nonprofit agency or the health department. A social bonus of a smoke-free environment is that teachers and administrators provide excellent role models of nonsmoking adults.

THE SOCIAL ENVIRONMENT

The social environment promotes good health in daily, often subtle, ways. Interactions between students and staff, as well as interactions among staff members, can reinforce lessons taught more formally in class. A healthy social environment nurtures student achievement and encourages physical activity, participation in extracurricular activities, good eating habits, and open communication. It is also free from violence and crime, drugs and drug dealing, and students who carry weapons.

Schools can foster a healthy social environment by actively promoting the school as a center for excellence, having and enforcing strong policies against carrying weapons in school, enforcing drug-free school zones, and sponsoring campaigns to promote school as a "safe space." At a more subtle level, school management that facilitates shared decision making and cooperative learning in the classroom also promotes a healthy social environment.

Programs that focus on staff wellness have been highly successful. Administrators report lower absentee rates, fewer health claims, and higher morale for staff participating in the program. (American Association of School Administrators, 1987) Wellness programs for staff can include stress tests, health screening, help to stop smoking, and exercise classes. Not only do students see teachers "practice what they preach", students also benefit from having fewer burned-out, stressed-out teachers in their classes.

THE EMOTIONAL ENVIRONMENT

Students' learning is dramatically affected by the climate of the school and the expectations of teachers. If teachers expect black and Hispanic students, as well as girls of all racial and ethnic groups, to perform poorly, these students are likely to fulfill these low expectations. And, if teachers believe that minority students are capable and smart, these students are likely to succeed. (Neckerman and Wilson, 1988)

Historically, nonwhite children have faced outright discrimination in schools. Even today, disciplinary action, reprimands, suspensions, and expulsions all occur at much higher rates for minority youth than for white youth. A healthful emotional environment requires policies and programs that foster, not inhibit, high achievement by these young people. (Fine, 1988)

People are increasingly recognizing the harmful effects of another bias, as well. Homophobia—the irrational fear or hatred of homosexuality—is harmful to all students, both straight and lesbian or gay. Boys may try to act tougher than they feel, or they may not develop close friendships with other boys, fearing they will be accused of sexual involvement, as well.

Girls may refuse to take nontraditional courses, such as auto mechanics, for fear of having their sexual orientation questioned. And some teenagers try to prove that they are not homosexual by becoming sexually active—and even parents—at an early age.

A school environment that denies the existence of homosexuality or tolerates verbal or physical abuse of gay and lesbian students sets the stage for these students dropping out of school.

On the other hand, an environment where homosexual teenagers are not stigmatized allows all boys and girls to choose activities—sports, drama, career paths, relationships—that are of interest to them without feeling pressured to fit into sex-role stereotypes.

Because HIV infection and AIDS is strongly linked with homosexuality in many people's minds, the fear of homosexuality makes it even more difficult—but not less important—to discuss HIV infection and AIDS.

Counseling services and referrals (for such things as substance abuse, suicide prevention, depression, and mental health problems) can also promote a healthy emotional environment.

In addition, training school staff to identify the signs of problems can help students get help before their problems become overwhelming.

Finally, students infected with HIV need a supportive emotional environment at school. Consequently, it is important for schools to have clear policies prohibiting discrimination against HIV-infected students.

COORDINATION

Almost all schools offer some sort of health instruction through specific courses and physical education; almost all schools offer some sort of health services, whether counseling, a health room, or a school-based clinic; and almost all schools want to provide a healthy learning environment.

BUILDING A HEALTH TEAM

What is needed is an approach that integrates each of these separate efforts. The many people who contribute to meeting the health needs of students need to communicate on a regular basis. These players include teachers, coaches, nutritionists, food service workers, counselors, psychologists, nurses and aides, clinic staff, child care workers, transportation supervisors, maintenance workers, school secretaries, and anyone else involved in student and staff health.

School health initiatives need a coordinator. One person needs to be responsible for calling regular meetings and coordinating all aspects of the school's health programs so that each person knows what his or her teammates are doing.

Members of the health team also need training in order to support their teammates and reinforce healthy behavior.

The coordinator and the health team have a lot of work to do, both inside and outside of the school. James O. Mason, former Director of the Centers for Disease Control, recommended that school partnerships include five groups:

public health agencies, the private sector, college and university faculty, parents, and state professional and volunteer agencies. (Mason, 1989) One of the first tasks of the health team is to set up a workable health record-keeping system that both provides necessary information and respects confidentiality requirements.

Finally, each school or district needs a person or team to reach out to the community—to increase awareness of health issues, to promote healthier citizens, to involve parents, and to gain access to professionals who can contribute to the school's health program.

Reinforcing Health Lessons

Every time a young person has an interaction with a health care provider, there is an opportunity for a learning experience. One clinic in Madison, Wisconsin, recognizes this opportunity and works to combine information with services to empower students to take charge of their own health. After a child is treated for an injury, the health care worker asks, "How will you keep this from happening again?" or, "How will you keep this from getting infected?"

WHAT IS THE RELATIONSHIP BETWEEN SCHOOL HEALTH PROGRAMS & OTHER COMMUNITY SERVICES?

Good health for children and youth concerns every facet of a community, not just educators. Meeting the interrelated health and educational needs of young people involves forging effective partnerships with health care providers, social service and other agencies, as well as religious and community groups. Indeed, putting a comprehensive school health program in place is a long-term solution to problems that have already reached crisis proportions in many communities.

Support for school health programs is strong when community members—from policymakers to parents—understand the

health problems of children, the consequences of these problems for society as well as individuals, and the degree to which other interventions have failed.

Comprehensive school health programs can help assure good health for children. As such, every community member has a stake in making these programs work. In the long run, taxpayers benefit when health care costs drop. Employers benefit when employees do not have to leave work to care for sick children. When these students join the work force, they are healthier and more productive workers with lower absenteeism and fewer health care expenses.

Research supports the concept that good school health programs make good economic sense for communities. A study by the Robert Wood Johnson Foundation found that a well-prepared school nurse could handle more than 95 percent of the problems brought to doctors. (Wisconsin Department of Public Instruction, 1986)

How Can School Health Programs Be Funded?

The long-term key to funding is broad support for the concept that comprehensive school health programs are a necessary investment in the future. If policymakers believe this, then funding will be found, whether by increasing the education budget or from nontraditional sources.

Innovative and collaborative approaches to funding programs for children and youth—especially those at risk of school failure—are springing up across the country. School-based clinics illustrate the range of potential funding sources for school health programs. Most of the funding for these clinics comes from nontraditional sources, such as private foundations, and state and federal health and human service budgets.

In many places, in-school health staff and services are funded in whole or in part by state or local health departments. Some health departments assign nurses to particular school

districts or buildings. (Center for Population Options, 1989)

Businesses across the country also make financial contributions to the health and education of children. One example of a community partnership program is the Houston (Texas) Health Adventure, which sends a healthmobile around to elementary schools. This project was sponsored by the Houston Academy of Medicine, Shell Oil, and the Harris County Medical Society. (American Association of School Administrators, 1987)

National and local foundations fund health programs, including those that are school-based. More than 40 percent of funding for school-based health clinics comes from private foundations. (Center for Population Options, 1989). As concern about HIV infection grows, good arguments can be made to these funders to support instruction as well as services. Although foundation funding can provide an important catalyst, the long-term viability of a program depends on securing more stable funding sources, such as public funding through education or health programs, and insurance and Medicaid reimbursements.

The federal government also funds health programs. The Centers for Disease Control promotes a comprehensive health program approach to addressing HIV infection and AIDS. Expanded school health services have been funded by federal Maternal and Child Health Block Grants, EPSDT (Early and Periodic Screening, Diagnosis, and Treatment Program), Social Services Block Grants, Community Health Centers, Family Planning, Medicaid, Adolescent Family Life Act, and National Health Services Corps.

As comprehensive school health programs become more commonplace, alternative and nontraditional funding schemes are certain to emerge. Many school health programs already receive some of their income from fee-for-service or insurance reimbursements. Health policy researchers have suggested new

options, such as using school systems to provide group health insurance to children, with the cost being shared by employers, families, and public funding sources. (Freedman et al., 1988) We can expect to see communities exploring these and other alternative sources of funding for child health in the years ahead.

Finally, a comprehensive health program can produce cost savings that offset new expenditures. The Dallas public schools estimate that they saved more than $150,000 in substitute teacher pay alone during the year they instituted a staff wellness program. (Blair et al., 1987)

HOW CAN WE ASSESS SCHOOL HEALTH PROGRAMS?

As more and more communities upgrade their school health programs, the demand for solid evaluations of the effectiveness of these programs will increase. This section discusses how success can be measured, what we know about the effectiveness of comprehensive school health programs, and strategies for reaching disadvantaged youth.

How Can Success Be Measured?

Evaluating a three-pronged comprehensive health program is important and difficult and includes measuring the process of implementing programs as well as program outcomes.

At the state level, process goals might include developing a statewide policy statement, requiring certification for teachers of health courses, adding a health course to high school graduation requirements, requiring or recommending that schools be smoke-free, or providing incentives for schools to offer only healthy foods in vending machines.

Comprehensive school health programs have two primary outcome objectives: to increase knowledge and to help students practice healthful behavior. To measure the first—increased knowledge—some states are

considering including health questions in their statewide testing programs. This will not only measure health knowledge; it will also send a message to students and educators that health is an important subject.

Measuring the extent to which comprehensive school health programs foster healthy behavior is more complicated than measuring knowledge. Short-term results of comprehensive health programs can be measured by such things as changes in the number of children being diagnosed and treated for vision or hearing problems, decreases in teen pregnancies as well as low-birthweight babies born to teens, and decreases in student absence due to illness.

Other long-term results are affected by many factors, of which a comprehensive school health program is only one. For example, a strong anti-drug program beginning in kindergarten is not likely to show results until those children reach the seventh or eighth grade, when they are making decisions about smoking, drinking, and using other drugs. Longitudinal studies are necessary to document long-term behavioral change.

What Do We Know About the Effectiveness of School Health Programs?

We have evidence of effectiveness in the area of health instruction. Good health education courses are very effective in increasing knowledge and have been shown to influence attitudes and behavior as well.

A study of 4,800 students in seven states evaluated the *Teenage Health Teaching Modules* (a comprehensive health curriculum). This evaluation found, for example, that students in THTM classes increased their knowledge of health issues significantly more than other students. The health attitudes of students exposed to THTM did not change significantly during the study, *but the health attitudes of other students systematically deteriorated.* THTM also affected the health practices of many students—senior high school students (but not junior high/middle school students) who had been exposed to THTM

reported a reduction in drug use and cigarette smoking. (Nelson et al., 1991; Errecart et al., 1991)

We also know that the more often health is taught, the more likely it is that students will change their health practices. Students with three years of health instruction were less likely to drink alcohol, take drugs, or ride with a drunk driver than their peers who had only one year of health instruction, a 1988 study found. (Metropolitan Life Foundation, 1988)

Proof of the effectiveness of comprehensive programs is rare, partly because comprehensive three-pronged programs are scarce, and partly because of the difficulty of documenting cause and effect in complex human behaviors. But research suggests that health courses alone—the historical mainstay of school health efforts—are not sufficient to improve the health of young people or change their behavior. To be effective, instruction must be coupled with services and integrated into the whole environment of a young person.

This comprehensive approach is illustrated by a program in South Carolina that sharply reduced adolescent pregnancy. This program included formal school instruction to increase knowledge and decision-making skills, as well as intensive community outreach to help parents and other community members improve their skills as parents and role models for youth. Although pregnancy rates declined significantly in the target area, they increased or stayed the same in the four control areas. (Vincent et al., 1987)

WHAT DO WE KNOW ABOUT REACHING DISADVANTAGED CHILDREN & YOUTH?

Today, we know a lot about intervention programs that successfully reach disadvantaged children and families. Most of all, they are intensive, comprehensive, and flexible. In *Within Our Reach*, Lisbeth Schorr outlines the

lessons of programs that work to break the cycle of disadvantage. Successful programs:

- Offer a broad spectrum of services, regularly crossing traditional bureaucratic lines to address the multiple needs of individual human beings;
- See the child in the context of family and the family in the context of its community;
- Hire skilled, competent staff who respect children and their parents and recognize that parents may need help themselves before they can make good use of services for their children;
- Respond to the individual needs of those they serve, even when those needs are outside of their program area, as they often are; and
- Reduce the barriers (of time, money, multiple referrals, scheduling, fragmentation, and isolation) that make heavy demands on people who may already be overwhelmed and underprepared, with the aim of making services coherent, easy to use, and reflecting a sense of continuity.

One of the reasons there are not more effective programs to reach disadvantaged youth is that these characteristics are difficult to achieve in a world where funding is typically categorical and turf issues are a fact of life. Also, although effective solutions are long-term, elected officials and policymakers are often consumed by immediate problems. Indeed, it takes a leader of vision to initiate a program that will not bear fruit until long after he or she has moved on.

At the same time, Schorr's traits of effective programs also distinguish successful schools. And these lessons make a good case for

comprehensive—rather than piecemeal—school health programs.

. . . . . .

Good health is a prerequisite to a good education. Effective education complements and supports the health and social services needed to overcome the conditions that put a young person at educational risk.

Schools are in a prime position to help ensure that children and youth get the healthiest start possible and have the tools they need to be healthy adults. Chapter IV outlines programs and strategies that schools are using to address HIV infection and AIDS, both as comprehensive programs and separate efforts.

STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
CHARLESTON 25305

GASTON CAPERTON
GOVERNOR

June 12, 1991

The Honorable Patricia Schroeder
Chairwoman
Select Committee on Children, Youth,
and Families
385 House Office Building, Annex 2
Washington, D.C. 20515-6401

Dear Congresswoman Schroeder:

The youth of our country represent 10% of our nation's population, and all of its future. As a state and a nation, we are faced with an unprecedented crisis in the health and well-being of our children.

For the first time in the history of the State of West Virginia, our young people are less healthy and less prepared to take their places in society as were their parents. All this is happening at a time when the challenges facing us are growing more diverse, more complex, and more competitive than ever before. We cannot allow our greatest resource, our children, to fall to such a plight.

West Virginia is not alone in this health crisis. Many other governors are facing similar situations. I applaud your select committee for working to assess this national crisis, and explore programmatic solutions.

West Virginia is taking the lead by taking solid, proactive steps to do something about this problem. We have involved the foremost people in business, education and health care to offer input and to make recommendations, so that together we can make a lasting change. West Virginia is taking the lead by involving individuals, organizations and agencies from around the nation to bring all our resources to bear upon this issue. Recently, the Legislature created a Children's Cabinet which serves as a vehicle for the development of comprehensive children's programs in West Virginia.

Our West Virginia Task Force on School Health, and its successor the West Virginia School Health Committee, is working to implement comprehensive community/school based health programs. We wholeheartedly agree with the Carnegie Commission's premise "no other knowledge is more critical than knowledge about health. Without it no other life goal can be successfully achieved."

Health promotion, disease prevention, access to health services, and cost containment are major issues with which the federal and state governments must deal effectively. Comprehensive school health programs help address each of these issues.

I am pleased that your committee will have the opportunity to hear the testimony of Lenore Zedosky, Assistant Director, Office of Educational Support Services in the West Virginia Department of Education. Mrs. Zedosky has been instrumental in the health education initiatives in our state. She is joined by Mrs. Rae McKee, the 1991 National Teacher of the Year. Mrs. McKee is from Slanesville. She will be able to articulate to you the integral relationship between health and education, and describe the impact of a caring school environment to the development of high self-esteem and self-efficacy of children.

Our problems with health will not go away if we simply ignore them. These are problems which we must solve together, or we will not solve them at all.

Sincerely,

Gaston Caperton
Governor

GC/sh

Building a Healthy Future

West Virginia Task Force on School Health

Comprehensive School Health Programs

The major goal of a comprehensive school health program is to lead students and school staff toward a healthy, productive lifestyle by empowering them to make responsible personal health decisions. Students must learn about the important interrelationships between personal health practices and community health status. They must learn to value their own health as a key component in attaining their life goals.

The eight components of a comprehensive school health program are: health education, health services, a healthy environment, physical education, food service, counseling/psychological services, teacher/staff wellness and community involvement. The West Virginia Task Force on School Health recognizes the importance of integrating all of these concepts in order to have a successful school program. A student who learns about preventive health practices in the classroom must have access to health services such as screening and treatment. The school environment must be physically, socially and emotionally nurturing, and the students must have counseling and psychological services available as they learn to cope with the many social issues facing them today. The school food service programs must reinforce the nutrition principles taught in the classroom and physical education must assist students to develop fitness habits that will serve them throughout the course of a lifetime. Finally, the school staff must be role models for students by believing and practicing what they teach in the class room. Community involvement, assistance and commitment to better health for its citizens is the framework that will support the other programs.

Therefore, the following sections of this report demonstrate the components determined by the Task Force as essential in improving the health of our students and the future health of our state.

West Virginia School Health Committee Recommendation

In order to establish the appropriate foundation for development of a comprehensive West Virginia School Health program, we recommend the establishment of a WV School Health Committee (including both governmental and non-governmental representatives) to collaborate in planning, implementing, and evaluating such a program. This committee will report to the Governor through the Cabinet on Children and Families. In addition, we recommend that West Virginia accept the invitation of the American Medical Association (AMA) and the National Association of State Boards of Education (NASBE) to participate as a pilot state in implementing CODE BLUE recommendations.

Core Recommendations

School Health Education

We recommend developing a pre-school-through-grade-12 comprehensive school health education curriculum and teachers' guide that implements updated WV Department of Education health education instructional objectives (1988). The curriculum should incorporate concepts and activities from the best existing guides (Know Your Body, Growing Healthy, American Red Cross, American Heart Association, etc.), and be focused on the health and behavioral issues identified in "Objectives for the Nation: 2000" and "Code Blue: Uniting for Healthier Youth." These issues include, but are not limited to, personal health, substance abuse, including tobacco, environmental/community health, family life/sex education, consumer health and nutrition, safety/first aid and seat belt usage, and mental health. The teachers' manual should include the curriculum and classroom materials, content and activities, parent materials, and evaluation tools. Pre-service teacher preparation and continuing education requirements should be developed for the curriculum.

School Health Services

School-based health centers should be established to ensure student access to multiple health and wellness services. Services available should be based on specific health priorities at each age level. These centers should be on the school site with formal linkages established with community health agencies and service providers, and should be made available for community health education. The number of school nurses should be increased to provide for primary coordination of services.

School Health Environment

In order for learning to take place, an environment must be provided that is physically safe, intellectually challenging, establishes social models for later life, and is emotionally nurturing. We recommend that each county board of education, in cooperation with the school improvement councils , periodically devise and review plans to ensure a school climate that is physically, intellectually, socially, and emotionally healthy.

Child Nutrition

School food service programs must become an integral part of the broader school curriculum, with food providers and educators collaborating on common goals. School food services should reinforce healthy eating behaviors by serving meals that reflect the Dietary Guidelines for Americans and provide a variety of healthy food choices. School lunches should provide for food choices such as salads, fresh fruit and low fat offerings.

Physical Education

We recommend that the West Virginia Board of Education review physical education requirements and develop recommendations for a program that emphasizes the following:

- An administrative mandate establishing a state coordinator for physical education and trained physical education coordinators where appropriate.

- Thirty minutes of daily physical education, exclusive of recess and lunch periods, for all children K-6; one regular class period daily for children in grades 7-8. Due to the impracticality of increasing physical education requirements for grades 9-12, intramural programs and wellness activities should be developed and students encouraged to participate in them.

- Periodic fitness testing in conjunction with complete health appraisals for every child K-12.

- An annual report on the fitness status of each school and each county will include in the WV Report Card published by the Department of Education.

Counseling

We recommend that effective personal/psychological counseling programs be established at all grade levels, with particular emphasis on the elementary grades.

School/Community Collaboration

School improvement councils must assume responsibility for providing information to county boards of education that will be used to develop plans to ensure that service groups, civic leaders and chambers of commerce have opportunities to become involved in school health issues. The county board of education should work with community medical providers, health education resources, and labor leaders to address the health needs of all community members, particularly children.

Teacher and Staff Wellness

Wellness programs for school personnel should be established. The Public Employees Insurance Agency (PEIA) should begin its required wellness program with school employees and develop a program plan that includes cost/benefit analysis, implementation timetables, incentives for participation and disincentives for non-participation. County boards of education should be encouraged to set up programs in conjunction with statewide wellness efforts.

School Health Education Recommendations

Every child in West Virginia should be provided with a quality comprehensive school health education program at each grade level (K-8) and during high school. It is important that parents, teachers, students, administrators, health professionals, and the community be involved in the development, implementation, and evaluation of programs. Further, the energies and resources of agencies and private organizations involved in health education should be harnessed and utilized as appropriate.

Health instruction should be provided through direct teaching devoted specifically to health; fitness/wellness instruction and activities should be provided through physical education; and both health and fitness instruction should be integrated into subjects such as mathematics, science, home economics, social studies, and language arts.

Certified health educators should be employed at the secondary level, and elementary classroom teachers should have preparation to teach health at their grade level. Increased emphasis should be provided on health teaching through staff development opportunities at the local level as well as through Regional Education Service Agencies and/or Professional Development Centers.

Teacher preparation programs both at the undergraduate and graduate levels must be based on the recommended West Virginia Health Education Curriculum. Because health issues change and new information is constantly added, it is important that faculty in institutions of higher education are cognizant of these changes and adjust programmatic offerings accordingly. Mechanisms must be developed to assure that faculty have opportunities to attend and participate in state and national programs dealing with these issues.

A mechanism should be provided for evaluating both the immediate and longitudinal effectiveness of the comprehensive school health program which includes assessment of health knowledge, attitudes, lifestyles, and behaviors.

School Health Services Recommendations

Develop or expand community-based school health advisory councils that are comprised of school nurses, parents, teachers, students and community service providers. The role of the advisory council is to make recommendations to county boards of education related to coordination of services, resource availability, school health programs, needs assessments, and evaluation. The advisory committee should establish formal linkages with faculty senates and school improvement councils.

Prior to school entry, all children should have fitness testing and a complete health appraisal that includes, but is not limited to, the components provided in the Early Periodic Screening Diagnosis and Treatment (EPSDT) examination. All educationally relevant health care findings should be shared with the school nurse to ensure coordination of services. The WV School Health Committee should make recommendations for additional examinations at specified intervals.

In order to enhance provision of services to children and families, communities should develop multi-disciplinary treatment teams that provide for comprehensive delivery of services to children at risk. Since numerous professionals often serve the same families, periodic review of family situations should provide for better coordination of needed services. Periodic reports of progress and problems should be submitted to the Children's Cabinet.

Case managers should be assigned to each family that has a child with special health needs. Coordination among agencies and personnel would be the responsibility of the case manager, and family needs would be coordinated by this individual.

All children, regardless of their special health care needs, should be fully included in classrooms which reflect their educational goals, and should be supported by a school health care plan designed and implemented by a team which includes the school nurse, primary care physician, the parents, classroom teacher(s), and other aides or volunteers who may assist in service provision.

The school nurse/pupil ratio should be modified to allow for adequate provision of school nurse services to all students. Thus, future staffing should provide for one nurse for every three elementary schools with a total enrollment not to exceed 1,000, one nurse for every three junior high or middle schools with a total enrollment not to exceed 1,000 and one nurse for every high school with enrollment not to exceed 1,000. If enrollment exceeds the above recommendations, additional nursing personnel must be employed. The role of the school nurse can then be expanded to assist with provision of other services such as some of those that are currently provided by physical therapists.

School nurse practice priorities should be based on the "Standards of School Nurse Practice" as defined by the American Nurses Association and on the data collected in the School Nurse Needs Assessment.

In order to increase services to eligible students, a better linkage should be established for students who are eligible for EPSDT (Early Periodic Screening Diagnosis and Treatment) or Pediatric Health Services and Medicaid Outreach. The schools need to know which students are eligible and then make appropriate referrals for services.

WV Department of Education school nurse certification requirements should be reviewed. A minimum of a baccalaureate degree with a major in nursing should be required and certificate renewal will be based on job-related graduate level course work.

A recruitment and marketing mechanism must be developed to ensure an adequate pool of qualified school nurses. The WV School Health Association should take the lead in making recommendations and developing a marketing strategy. Special incentives should be considered to attract well qualified personnel.

Immunization certificates designed by the WV Bureau of Public Health will be used for school admission. The certificates may only be issued by private physicians or local Departments of Health. Thus, schools will no longer be required to determine if immunization dates are within legal guidelines.

The WV Board of Education should ensure that when new schools are constructed, clinic space is provided that is accessible to students and community members.

Communities should be provided with the necessary technical assistance to enhance provision of adequate services to families. The WV School Health Committee can develop and disseminate information related to funding, services, staffing, etc.

The WV Department of Education and WV Bureau of Public Health should collect data at regular intervals related to youth risk behaviors, medical needs, and adult illnesses. The data should be utilized in determining the types of services to be offered in health centers.

An evaluation component should be built into all program efforts and information related to program effectiveness, and problems should be disseminated to groups working on school health issues.

School Health Environment Recommendations

The comprehensive school health curriculum should have a strong focus on nutrition, including integration of a food services component. Food services personnel, administrators, health teachers, coaches, home economists, and schools health nurses should be trained in effective ways to facilitate such integration and collaboration.

Considering that the **Dietary Guidelines for Americans** support a qualitative directional, rather than specific quantitative approach to dietary changes, the following is recommended for school meals:

- limit fat, particularly saturated fats;
- limit sodium;
- provide a variety of good food sources of dietary fiber and complex carbohydrates; and
- enhance the appeal and attractiveness of offered food.

A registered dietitian or qualified nutritionist should be employed in each RESA and at the West Virginia Department of Education to provide technical assistance to schools in working toward the **Dietary Guidelines for Americans** and serving students who have specialized nutritional needs (i.e., athletes, obese students, handicapped students, pregnant students).

Job descriptions and minimum academic standards should be developed for county food service directors.

In-service and pre-service training related to school food service goals, purposes, and programs should be required of all school personnel who administer food service programs or teach nutrition education.

Any professional who is responsible for health "instruction" (elementary, health, physical education, home economics, athletic trainers) should be required to complete at least three credit hours in nutrition as part of the undergraduate and/or graduate teacher preparation program.

The school cafeteria should become a learning laboratory by reinforcing nutrition concepts that are taught in the classroom. Parent education programs must be implemented to assist parents in their role as the major determiners of children's eating habits.

School administrators must adopt policies and practices that support the goals of school food service and nutrition research findings. Policies prohibiting the sale of non-nutritious foods should be strictly enforced, including the sale of food for profit-making purposes.

A public information program should be designed and implemented at the state, county and school levels to expand service to all students by overcoming negative images of school food service programs.

Physical Environment

The WV Department of Education and the WV Bureau of Public Health should establish a program to monitor the results of tests for lead and radon in schools, and to follow up on the success of measures taken to eliminate contamination discovered as a result of an aggressive testing and monitoring effort.

The legislature and the WV Department of Education should support inclusion of environmental sanitation in standards necessary in individual school and in county accreditation. Steps should be taken to strengthen the decision-making capacity of school administrators to address solutions for environmental problems within each school. Close cooperation and collaboration between health departments and county school systems should be encouraged.

Standards and inspection schedules should be established for dealing with hazardous materials such as PCB spills, cleaning fluids, pesticides, and unused laboratory chemicals, etc.

Recycling programs are recommended in all schools, and use of non-recyclable items should be discouraged.

Schools should be tobacco-free, including all buildings and the outside campus. Smoking designated areas or smokeless tobacco-use areas will not be permitted on school grounds, including during extracurricular activities. Students and teachers should be provided tobacco cessation programs at the school site.

Physical Education

A minimum of three days per week of physical education, grades K-8, will be geared to aerobics and cardiovascular conditioning, and muscular endurance, strength and flexibility (activities could include aerobics, walking, tennis, etc.). The remaining two days could include games, sports, and leisure skills. Because of the impracticality of increasing required physical education for grades 9-12, programs should be developed and students encouraged to participate in intramural and wellness programs. Schools should be required to offer electives in lifetime fitness activities, including cardiovascular-type exercise.

The state coordinators for physical education would have credentials that include a graduate degree in Exercise Physiology with an undergraduate degree in Physical Education; or an undergraduate degree in the realm of sports medicine with a graduate degree in Physical Education.

School Worksite Wellness

An annual "Mountaintop Conference" should be convened to train teams from individual schools in developing and implementing a teacher/staff wellness program as the cornerstone of a comprehensive school health program. Pilot sites should be chosen for implementation on a phased-in basis.

The recommended wellness programs should be geared to help improve the health of school systems, schools, school administrators, teachers, staff and most important, children.

Extracurricular Activities

Increase the role of the Secondary Schools Activities Commission in promoting health behavior of students, especially those athletes under their guidelines, and increase the health and safety knowledge and skills of instructors and coaches.

School/Community Collaboration

Schools should work with community medical and health education resources to establish community-wide wellness programs that address the health needs of community members of all ages. The programs should meet the specific needs of the community and the school, and should rely on high levels of community participation and involvement. Communities and schools should cooperate in setting building utilization guidelines for community programs.

Community members should become involved in setting standards related to the access of teens to tobacco vending machines in communities and the enforcement of laws prohibiting the sale of tobacco and alcohol products to minors. In addition, civic leaders can receive in-service training on health issues that will enable them to serve as resource people and as guest speakers in the schools. Businesses involved in school partnerships should be encouraged to provide creative activities that enhance healthy lifestyles of students.

Counseling Services

Increase the funding for elementary counselors to provide services to the large number of students presently receiving no services or marginal services. Provide a minimum of one counselor per school with a minimum enrollment of 240. Schools having fewer than 240 students should have pro-rated counseling services.

Decrease the paperwork associated with many counselor positions in order to provide more direct counseling through providing clerical assistance or alternative methods for handling the increased information needs of the WV Department of Education, central offices, accreditation bodies, colleges and universities, exceptional students, and accountability emphasis.

Mandate comprehensive developmental guidance programs using advisory committees and increased participation of teaching staff in the delivery of guidance and counseling concepts and practices to students.

Provide increased opportunities for upgrading skills of counselors and teachers to address the current needs of students associated with changing economics and families (for example--divorce groups; single parenting; suicide prevention; parent education; pregnancy prevention; minority concerns; non-traditional careers; and accepting diverse lifestyles associated with different cultures and ages).

Administration/Funding Recommendations

Funding

The Legislature needs to ensure that an ongoing source of funding be established for the planning, implementation and evaluation of comprehensive school health programs of at least $1,500,000.

The School Health Committee should work with officials representing block grants and categorically funded programs (i.e., Drug Free Schools and AIDS Education) so that these programmatic efforts are a part of the comprehensive school health program. They should also work with officials at the Department of Health and Human Resources so that health education designated funds received as a part of their grants are utilized in the comprehensive school health program.

Some of the tax revenue which the state currently receives or new revenue from cigarettes and other tobacco products and alcohol, and from premium taxes on health, life and auto insurance policies, should be earmarked for funding the comprehensive school health program.

The WV School Health Committee should also seek funding from other government and private sources for the planning, implementation and evaluation of a comprehensive school health program.

Funding must be identified prior to the legislature or WV Board of Education mandating any changes in present ratios or numbers of school nurses, counselors, physical education coordinators or other school health personnel called for in the implementation of this report.

Textbooks

It is recommended that the West Virginia Board of Education Policy No. 2445 be amended to contain the following conditions:

Textbooks and/or curricula could be included on the approved list only if the publisher will provide a three-year review of content to identify obsolete information and provide new and/or updated information as a supplement.

Exemptions for purchase of textbooks and/or curricula would be for a one-year period only. Any county board of education which is granted exemption for purchase of textbooks and/or curricula will be required to adopt a textbook and/or curricula and purchase the textbooks and/or curricula the following fiscal year.

The West Virginia Board of Education should establish procedures to evaluate curricula, composed of modules and including possibly student workbooks, audiovisuals, puppets, etc., that could be utilized in place of basal textbooks and/or curricula in the health education subject area. If other than traditional textbook materials are adopted, then training monies must be allocated.

Seat Belts

It is recommended that the Governor issue an Executive Order requiring all state employees to use seat belts while in the performance of their official duties, both in state vehicles and private automobiles. In addition, the legislature should enact law that requires all vehicle occupants to wear seat belts.

Staff Development Time

It is recommended that the West Virginia Legislature enact legislation which will provide an additional eighteen hours of staff development time each year for all professional staff members. It is the responsibility of the West Virginia Legislature to determine the means of providing the additional eighteen hours. The Center for Professional Development and the County Professional Staff Development Councils should devote attention to comprehensive school health program training.

Drug-Free School Zones

We recommend that signs designating drug-free school zones be posted at appropriate locations near all public schools in the state of West Virginia, at a maximum cost of between $50,000 and $100,000. We would recommend that these signs be placed in tandem with the existing school zone signs, and that funding for sign purchase be solicited from the Governor's Drug-Free Communities Program.

Evaluation

It is recommended that a block of questions to measure health knowledge, attitudes and competencies be included in the standardized examination given each student every year. These questions should be derived from the health education instructional goals. Results of this testing will give some indication of the program impact.

A Course For the Future

The years ahead present our state with a rare combination of challenges and opportunities. Young people today face an unprecedented number of health risks and health problems. More than ever before, there are increased opportunities for an entire generation to fail in realizing their potential. But there are also more avenues that lead to success.

There are powerful solutions to the problems at hand. West Virginia can show significant improvement in the health status of its citizens by establishing progressive comprehensive school health programs. Communities, businesses and individuals will all benefit from these collaborative efforts. Healthy young people will become better educated, more productive and be far less likely to need premature, costly social and health services.

This Task Force has charted the course for a healthier future in West Virginia. This course will not be easy--solutions to the health problems facing our young people today will require the combined commitment, time and energies of state government, schools, businesses and individuals. Yet, meeting these challenges and overcoming them is the only sound means to ensure a brighter, healthier future for our state and our nation.

THE HARRISON COUNTY HEALTH EDUCATION ENRICHMENT PROGRAM

The Harrison County Health Education Enrichment Program began as a pilot project in 1987 as an effort to improve, through health education, the overall well-being of West Virginia children. A nationally-recognized curriculum, strong grassroots and top-level administrative support, and concepts basis to healthy living are key components of the program. Since its inception, the program has grown from a trial basis in three schools to an integrated educational component for some 3,000 children in six schools. (Three additional schools will be added in the fall of 1991.) This approach to health education has and should continue to serve as a model for West Virginia schools.

The impetus for this program is from the foresightedness and generosity of the C.E. Compton Family of Bridgeport, West Virginia. Monetary and technical support are provided through the C.E. Compton Chair of Nutrition Research at WVU. The program is a partnership effort between the Harrison County School Board, Grafton Coal Company, Salem-Teikyo University, and West Virginia University. School parent-teacher organizations, classroom teachers, local medical societies, private businesses and community volunteers help conduct program activities and give local support. Such a broad spectrum of resources and guidance from all facets of the community is an inherent program strength.

The program is built on basic health education concepts. The curriculum and activities impart a sense of personal empowerment and ability to make a difference in one's life. Children become aware of personal choices and how choices impact their well-being. They also gain a sense of responsibility for their own health. Specific goals of the program are:

- to provide a comprehensive and sequential health education program to kindergarten through the sixth grade.
- emphasize a nutritious school lunch menu that is served in a climate that fosters good eating habits.
- to provide students with a basis for lifestyle habits for health-related physical fitness, stressing aerobic activities
- foster a more personal view of health through skill building, problem-solving, informed decision-making and an awareness of the responsibility for individual health.
- collect data on students' physical fitness, diets, attitudes, behaviors, and health knowledge.
- make health education a school-wide activity open to everyone
- develop a better understanding of the determinants of health-related behaviors in children and how to change them
- provide a health education program that will improve the self-esteem of students.

The Know Your Body (KYB) Program developed by the American Health Foundation is the curriculum base for the Enrichment Program. KYB is a classroom based, health education approach designed to motivate children to adopt healthier lifestyles and to feel responsible for the care of their own bodies. It is directed towards altering health risk behaviors during the formative years of childhood. Health and lifestyle topics are taught within a frame work of a "wellness approach" that emphasizes the physical, intellectual, emotional and social needs of children. The major topics include smoking, accident prevention, nutrition and exercise with applications to other health areas.

The Enrichment Program also includes a unique screening component, the Positive Health Profile, which provides an educational opportunity for students to learn more about their health status. The screening includes measurements of height, weight, blood pressure, pulse and cholesterol. Results are mailed to parents and children receive a copy in a personal health booklet.

Individual participation in program activities is encouraged and provides opportunities for personal growth. Tasting parties introduce students to new foods and offer choices for alternative snacks. Plays, writing and art contests, and musicals focusing on health-related topics enhance individual self-esteem and increase learning. Science projects and community health fairs bring health concepts out of the classroom and into the home and community.

Program costs and administrative attention are most intense during the start-up phase. Text books, teaching materials, learning modules, health screening supplies, personnel, and evaluation materials are about $30 per child for the first year. Subsequent years cost $18-20 per child. A greater reliance on in-kind contributions, borrowed resources, volunteer personnel, and community ingenuity can reduce costs.

Important information on the status of children's health has been collected through out the program. Data from the Positive Health Profiles indicates about 60% of children have cholesterol levels above the 1990 National Health Objective of 150 mg/dl. Heights and weights of children, when compared to the NHANES II sample, show Harrison County girls an average of 5% heavier and boys an average of 10% heavier than similar children nationwide. Questionnaires indicate children are knowledgeable about dental health and effects of cigarette smoke, but know less about nutrition, heart health, accidents and exercise.

There is measurable success with this program. Participants have demonstrated gains in knowledge, personal behavior changes and a greater awareness of personal health status. School environments have also changed as a result of the program. Lunch menus have incorporated a greater variety of healthy foods and physical fitness classes have added more aerobic activities. On a broader scope, the program has provided insights for future program development and refinement. The Governor's Task Force on School Health has suggested using this program as a blueprint for other health education efforts.

Several awards highlight the program's success. State awards include the West Virginia State Department of Education's "Leaders of Learning Outstanding General Education Award", August 1989, and the West Virginia State Health Education Council Health Advocacy Award, April 1990. Nationally, the effort has been recognized by the U.S. Department of Health and Human Services, "Secretary's Award for Excellence in Community Health Promotion", October 1990; the Centers for Disease Control with the "Program Evaluation Award in Community Health (PEACH)", April 1990; the American Medical Association's "Recognition of Excellence in Coordinated Comprehensive Health Education and Prevention Programs" award, May 1990; and the National Association for Sport and Physical Education, "Recognition of the Fitness Fun Videotapes", March 1990.

However, the greatest measure of success will be a healthier generation of West Virginia children.

PROJECT
RESPECT

P.O. Box 97
Golf, Illinois 60029-0097

Director: Kathleen M. Sullivan

June 27, 1991

Honorable Frank R. Wolf
Ranking Minority Member
U.S. House of Representatives
Select Committee on Children, Youth, and Families
385 House Office Building Annex 2
Washington, D.C. 20515-6401

Dear Mr. Wolf,

Attached are two representative letters of the many we have received over the years from teens who are reaching out for help. It is clear upon reading these that no amount of contraceptives can solve or prevent the emotional trauma that is crying out through these letters.

The secondary virginity concept is the appropriate answer and is why they are so appreciative of our materials.

Thank you for the opportunity to testify before your Select Committee on June 17th. I request that these letters be entered as part of the record.

Sincerely,

Kathleen M. Sullivan

Kathleen M. Sullivan
KMS/sph

November 8, 1990.

Mrs. TINSLEY, I want you to know that I think this course (sex respect) is just "*great.*" I know, I already told you that in child care when we talked about sex respect also. I hope everyone learns *a lot* from this and understands how important staying a virgin really is. Sex *is not* as good as what people say it is. I know from experience. I'm not proud of that experience, though. God, you don't know how bad I wish I was a virgin. When you start having sex at 12 years old, then every guy expects it from you from that day on. Almost no matter what guy you go with.

It's awful! If I would not have let a 22 year old guy talk me into it, then I would *not* be in this situation and I wouldn't have these problems and feeling depressed all of the time!! If only I knew what I know now! I didn't know it would be this way! It isn't fair! I was only 12! This guy (22 years old) told me that he loved me *sooo* much. I actually believed him! Then right after that he left to California or something like that. I *never* seen him again! I'm 15 now and the pain never stops!

You would think that I would learn after that. But, I fallen for their lines every time. But, I'm not gonna fall for it again! Sometimes I think my problems would go away if I would run away but, just haven't been able to leave!

I'm lost and don't know what to do next! Not too long ago, I found out I was pregrant. But, I had a miscarriage. I love kids and babies, but, I don't think I need one yet. I guess it was for the best. I have a boyfriend now, he says he loves me, God, I hope its true. I just want someone to love me!! That's all I want. Is that so wrong?

It isn't fair!! It just isn't fair. If only I was a virgin. When you said in class that on your honeymoon and then when you lose your virginity to the man you love and he loves you, and that it would be so special. I about cried. I want it to be special for me too. Why do guys lie to get sex? Especially to kids.

January 25, 1988.

DEAR PROJECT RESPECT, Hello. My name is Jacki and I'm 16 yrs. old. I really have a serious problem. I'm pretty much the only girl in my neighborhood. There is a group of boys in the area (between 7–10 boys). Last summer the boys sort of "discovered" me. I never thought that so many guys would want *me*, fat Jacki. But they did. I never had too many boys in my life til I met them. They all started flocking around me. It was great. I felt so wanted. The only real problem I had was choosing which boy to please first.

But after a while I started feeling really down on myself. I'd feel real lousy when I left. It's only getting worse. I have a reputation now. The boys don't seem to mind sharing me amongst themselves. But lately they seem to get their kicks by putting me down. But I want so much to get that wanted feeling back that I return day after day. And day after day when I leave I feel depressed. Sometimes suicidal. I don't want to want to go back. All I get is heartache.

I want to prove to myself that I don't deserve what's happening to me. I don't want to thrive and depend on their sexual charities. I want to improve myself and lose weight. Maybe then I can show myself that I'm better than them.

The reason I wrote you is because it sounds like you really can help me. The ad in the magazine said "When you've gone too far." That's what I've done. But, if you can't help me do you think you could refer me to someone who can? I really need some self esteem. Please respond quickly, if possible.

Thank you very much.

JACKI.

June 13, 1988.

DEAR PROJECT RESPECT, It's taken me many months to get up the nerve to send this. But I'm doing it today! A good day comes along and I think well, the boys aren't so bad. I can deal with it myself. But I can't. I've proved that to myself a million times but the evidence doesn't seem to show clearly enough for me to know that I need help. I do need help. Do you have any meetings or anything?

The summer is only days away and all my free time will be spent doing sexual deed for the boys unless something comes up. I hate myself for what I am doing more so now than ever before. I feel like a fucking whore! I can't go on this way. Please, please help me.

By the way I'm 17 now.

Very Sincerely Yours,

JACKI.

Prepared Statement of Lewis P. Lipsitt, Ph.D., Executive Director for Science, The American Psychological Association, Washington, DC

The risky business of being an adolescent in 1991, and the special needs of the adolescent population, are now getting the attention of Congressional policymakers, thanks to two important events. The first is the publication of the Office of Technology Assessment's report, Adolescent Health, released this spring. The second event is this hearing. The House Select Committee on Children, Youth and Families is to be commended for focusing its attention on the importance of the adolescent years for sound life-span development, and the multiple risks that face today's young people as they negotiate the delicate age of being neither child nor adult.

As a developmental psychologist with a longstanding interest in the welfare of children and young people, my research has focused on infancy, early child development, sudden infant death syndrome, and behavioral self-regulation in adolescents. I am a professor of psychology and medical science at Brown University, where I have been on the faculty since 1957, and am Director of the Child Study Center there. I am currently on a leave of absence to serve as Executive Director for Science of the American Psychological Association. Through my research and policy work, I have come to believe that as important as prenatal and early child care are to the healthy development of children, the adolescent years present special hazards that can result in tragedy during these critical years or may result in events that cause life-long adversity.

As visiting scientist at the National Institute of Mental Health in 1986 - 1987, I had the opportunity to explore in depth the risks to young

people that this hearing focuses on today. I strongly believe that the science of psychology holds the key to understanding how and why our children make critical choices in their lives, and how our society can learn to respond more effectively to the diverse needs of young people.

Risks to young people today are numerous, and have been well-described. Still, there is an important point to emphasize: More children and young people die or become debilitated from what I describe as "behavioral misadventures" -- unintentional injuries, suicide, homicide, abuse of alcohol and drugs, and dangerous sexual practices -- than of all diseases combined. Because the behavior of adolescents figures so prominently in the morbidity and mortality of this group of people, these causes of death and injury are almost entirely preventable. We bring our children today into a dangerous world. Adults in this country must, therefore, provide the children with the resources and skills to navigate the difficult course of development.

Let's begin by looking at unintentional injuries. For many years, both the public and scientists called them "accidents." The term "accidents" implies that the events are random and uncontrollable, and, consequently, they were once given little research attention. Now, both the Centers for Disease Control (CDC) and the National Institute of Child Health and Human Development (NICHD) are giving the subject increased attention and funds, in large part because Members of Congress have directed them to do so. Not surprisingly, the research is showing how unintentional injuries can be prevented, through increased attention to the environment, increased use of protective gear, and increased public awareness.

The OTA report, Adolescent Health, catalogs the staggering economic costs of injuries. Injuries sustained in 1985 by young people aged 15 to 24 have a lifetime cost of $39.4 billion. (Separate data are not available for the adolescent years of 10-18.) Given these costs, the federal government should prudently increase its commitment to research and preventive programs. For example, the entire budget of the National Institute of Child Health and Human Development in Fiscal Year 1991 is only $478 million, and its research budget for injuries is only a fraction of that amount. It is time our nation put the kind of resources into research on prevention of injuries that we now spend for research on cures for adult diseases. Surely we can do better.

Among the choices faced by adolescents are whether to begin using alcohol, cigarettes, and other drugs. The National Survey of High School Seniors showed that, in 1985, about two thirds of seniors were drinking alcohol within a month of the survey, and about one fourth were using cigarettes and marijuana. Fifteen percent of the high school seniors surveyed could be considered at high risk, either because they were smoking every day, drinking heavily, or using other drugs.

The good news is that lifetime prevalence rates of use for most substances declined, according to the survey of seniors, from 1979 to 1985. Still, there appears to be a core of students, from fifteen to twenty percent, who begin using substances early, and continue through high school. These children not only put their own health at risk, but through behaviors such as drinking and driving, they risk others' health as well.

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Based upon conferences which I chaired at the NIMH a few years ago, I have co-edited a volume soon to be published on risk-taking and behavioral self-regulation, particularly in adolescents. One of the authors, in her own excellent book called Adolescents at Risk, summarizes the literature on the antecedents of substance abuse. The risk markers for later substance abuse that Joy Dryfoos identifies are:

- use of substances at an early age (10-12);
- lack of expectation that school will be a successful experience; low grades; truancy;
- lack of parental support and guidance;
- consorting with peers who use substances, and favoring those peers' opinions over those of parents and other adults;
- being a nonconformist, or rebellious.

There are race and gender differences. Males are more likely to be involved in heavy drinking and drunk driving; female seniors are more likely to smoke cigarettes and to use some drugs, such as amphetamines. Black females report lower usage of all substances than other groups, and Dryfoos suggests that in most surveys where racial differences are measured, black students show lower rates of overall usage than whites.

Regarding substance abuse, there seems to be a national consensus to prevent children as long as possible from beginning to smoke or drink or use drugs. There may be little disagreement about the message, but there are varying ways of delivering that message to target audiences of adolescents. Some are more successful than others. Several guiding principles for

targeting prevention efforts are mentioned by Dryfoos; I will expand on three of them.

First, behavioral research suggests that the more a prevention message is reinforced by a child's environment, social institutions and family, the more likely it is to take hold. That is the reason community-wide efforts, directed at businesses, the media, youth agencies, churches and families, should complement programs in the schools.

Second, because a number of risk factors, such as poor school performance, are known to be antecedents of substance abusing behavior, it makes sense to focus specific attention on those problems. A dropout prevention program may reinforce a program to prevent substance abuse.

Third, because the middle school years mark the beginning of adolescence, prevention efforts focused on this younger group may have a better chance of being heard, before the initiation of harmful behaviors.

There are many other risks in adolescence that this Committee has heard about in greater detail: the risk of teenage pregnancy, sexually transmitted diseases, AIDS. In these areas and others, the message of prevention can work, provided adults are willing to commit the time, the expertise and the resources that will enable our children to lead healthier, more pleasing lives.

Less than one half of one percent of the diagnosed AIDS cases occur among teenagers, but this is not cause for optimism. Some studies suggest that the median time between exposure to the human immunodeficiency virus and development of AIDS is as much as ten years. Therefore, many of the cases of AIDS appearing now in youth in their twenties were contracted when

the victims were teenagers. At least 40,000 new cases of HIV exposure occur each year, and as many as one in ten may occur in teenagers.

Adolescents are less likely to use condoms to prevent infection than adults, and those who use them may be less likely to use them consistently and correctly. According to Adolescent Health, in 1988, more than half of 15 to 19 year olds reported having had sexual intercourse in the last three months, but only 22 percent of the sexually active females reported use of condoms. In a retrospective study which I and a colleague at Brown University conducted with adults, it was clear that alcohol use lowers the threshold for engaging in dangerous sexual behaviors. In order to prevent the spread of HIV in the general population, it must be prevented in adolescents. For sexually active adults and adolescents, the prevention method is the same: condoms. It is imperative that adults provide adolescents with information and equipment to prevent the spread of AIDS.

Suicide is one of the most tragic behavioral misadventures. In 1987, fifteen percent of tenth graders in a survey reported making at least one suicide attempt. Depression is highly correlated with suicide attempts and completions. Female adolescents, for reasons that are only partially understood, face a much higher risk of depression than do their male peers. Although female adolescents are less likely to complete suicide than males, data from clinical populations show they attempt suicide three times more often.

In 1987, the American Psychological Association formed the Task Force on Women and Depression, a multidisciplinary group of scientists, clinicians, and mental health activists. The Task Force released its report

in March of this year. The report, Women and Depression: Risk Factors and Treatment Issues, contains a review of the scientific literature, and a number of recommendations for further research. In its review of the increased incidence of depression among adolescent females, the Task Force noted that several factors correlate with both male and female adolescent depression: Low parental support; low self-esteem; low levels of attachment to either parents or peers or both; and depressed parents. But the gender difference is less well understood. There is evidence that satisfaction with one's own body appears to be more closely associated with self-esteem in adolescent females than in adolescent males. Other studies show that girls are more disparaging than boys in appraising themselves, and reveal more disturbances in self-image. Sexual abuse may also account for some of the difference; adolescent females are two to three times more likely to be victims of sexual abuse than adolescent males.

It is critical that increased research attention be given to depression and other mental disorders in adolescence. According to the recent OTA report, treatment costs alone in 1986 for mental health problems in adolescents, aged 10-18, were $3.5 billion. Many adolescents who need treatment have no access whatever to it, so it is clear that the costs to our society are actually much higher. The ways in which youngsters become depressed have been extensively studied by psychologists, who have been able to evolve effective treatments for this disorder through both laboratory and clinical investigations.

As a scientist, I firmly believe that the best policy efforts must grow from research. Before a prevention program can be designed, the target

audience must be well defined and understood. What are the attitude differences between younger and older adolescents? What are the gender and racial differences in unintentional injury rates and substance abuse rates? Which groups of adolescents are most likely to seek counseling? What are the specific mechanisms and processes through which some children and adolescents go into a downward psychological spiral from poor self-esteem to profound sadness to serious depression? This type of information can vary by geographic region, even by school district. Good research is essential, and it is expensive. But Congress should demand that better information be made available in order to target scarce resources toward more effective programs.

Well-designed research demonstration programs can serve as test cases for the best ideas in prevention. These projects should have strong evaluation components, and provide for several years' follow-up, to demonstrate the long-term effectiveness of each project. The better the evaluation, the more Congress and state governments can be sure of the programs which work in different areas.

Another important component in making the adolescent years less risky lies in protective laws. Very few jurisdictions mandate the use of bicycle and motorcycle helmets, despite the data collected by state medical examiners indicating that in cycle accidents, the victims, often children, are two to three times more likely to die if they are not wearing helmets. This is a behavioral matter, like the issue of whether parents use automobile safety seats for their children. Protective laws are an integral aspect of the community-wide reinforcement of prevention messages.

I appreciate the opportunity to submit this statement, and remind the Committee that the American Psychological Association is willing to assist in spreading the word, and supporting truly informative research, about the needs of adolescents, and the ways in which we can all help make their world, and ours, safer.

PREPARED STATEMENT OF MURRAY L. VINCENT, ED.D., PROFESSOR, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF SOUTH CAROLINA, BAMBERG, SC

A Brief Summary of

The School/Community Program for Sexual Risk Reduction Among Teens

Bamberg, South Carolina

The program herein described has existed in Bamberg County, South Carolina since October, 1982. The outcome objective is to reduce the occurrence of unintended pregnancies among unmarried adolescents. Operating under the premise that teen pregnancy is a complex sociocultural problem with many contributing factors, the intervention employs multiples of strategies directed to all members of the target community. Educational programs for teacher training, parent training, community awareness, K-12th grade instruction, and peer leadership have been orchestrated to positively influence teens to delay/abstain from first sexual intercourse, and for those sexually active, to effectively use contraception. Additionally, contraceptive access and referrals have been provided through school nursing services, and for a short period of time during 1986-1987, through the available services of a school-based clinic. Due to South Carolina legislative action the contraceptive services were forbidden early in the spring of 1987.

The outcome objective is assessed yearly through data acquired from the South Carolina Vital Statistics Division for pregnancies among 14-17 year old females. Three South Carolina

counties with similar demographic makeup serve as controls for comparative purposes. Pregnancy rate per 1000 females (live births plus fetal deaths plus induced abortions) is computed yearly by this division of the South Carolina Department of Health and Environmental Control. Trend analysis of rates prior to the intervention, and continued thereafter during the ongoing project, provide important evaluation results. Pregnancy rates of 54 to 60 per 1000 females ages 14-17 years prior to the intervention were reduced to rates of 25/1000, 25/1000 and 23/1000 in years 3-5 of the project. Pregnancy rates from 1987 to 1989 have been less favorable as they have slightly increased. Rates in the comparison counties have remained relatively the same over the years of assessment.

Why the significant decline over 3 years and then the recent rise in pregnancy rates in the past 3 years? Our own analyses plus the extensive secondary analyses by Research Triangle Associates (funded by the Centers for Disease Control) can be summarized as follows:

1) Broad-based education programs throughout the community, in conjunction with the availability of contraceptives and referrals, works in synergy to decrease teen pregnancy and explains the three years of decreased pregnancy rates in the intervention county.

2) The absence of easy access to contraceptive services (due to S.C. legislative action) appears to have contributed to the recent rise in pregnancy rate even though the educational program has continued vigorously

over this time period.

3) Thus, contraceptive services alone, or an educational program alone, will not provide ample dosage to offset this major socio-cultural problem. Both must exist if teen pregnancy reductions are to be expected.

It is appropriate to note that the program and the data collected over the 8 years of the project are consistent with the theories and past studies conducted by social and behavioral scientists. These theories and studies, plus the results of our small project, should be heeded if our nation expects to impact upon the problem of teen pregnancy.

Murray L. Vincent, Ed.D.
Professor
School of Public Health
University of South Carolina

ANSWER FROM LENORE ZEDOSKY TO QUESTION POSED BY CONGRESSMAN FRANK WOLF

The Harrison County Health Education Enrichment Program

The Health Education Enrichment Program began as a pilot project in 1987 as an effort to improve, through health education, the overall well-being of WV children. A nationally-recognized curriculum, strong grassroots and top-level administrative support, and concepts basic to healthy living are key components of the program. Since its inception, the program has grown from a trial basis in three schools to an integrated educational component for some 3,000 children in six schools. This approach to health education has, and should continue to serve as a model for West Virginia schools.

Organized as a partnership effort between a local school board, a private business, and two universities, the program incorporates several entities. Parent organizations, teachers, local Medical Society auxiliaries, and community volunteers all play a part. Such a broad spectrum of resources and guidance from all facets of the community is an inherent program strength.

Basic health education concepts are the foundation of the program. The Know Your Body (KYB) Program developed by the American Health Foundation is the curriculum base for the program. The lessons and activities impart a sense of personal empowerment and ability to make a difference in one's life. Children become aware of personal choices and how those choices will impact their well-being. They also gain a sense of personal responsibility for their own health.

The Enrichment Program includes a physical assessment which is an opportunity for students to learn more about their health status. The screening includes measurements of height, weight, blood pressure, pulse and cholesterol.

Important information on the status of children's health has been collected through out the program. Knowledge questionnaires were given to participating and nonparticipating schools to assess program effectiveness. Children in the program scored higher on 7 of 8 categories of knowledge, with the greatest gains in areas of diet, exercise, heart health, and effects of tobacco. In the nutrition category, children in the program scored almost 20% better than those not receiving the curriculum. Changes in personal behaviors have also been evident at participating schools, with children requesting salad bars and more nutritious snacks.

This program has had many successful outcomes. Namely, it has brought together a network of community leaders working to implement a comprehensive school health program; it has provided valuable information about children's levels of knowledge and physical health status; it has served as an impetus for the formation of the Governor's Task Force on School Health; it has demonstrated a screening program that encourages high participation rates and provides important information; and it has incorporated evaluation and feedback mechanisms that allow for program change.

Finally, this program has been applauded by state and national organizations for its innovation. The CDC Peach Award, the AMA Recognition of Excellence Award, and WV Leaders of Learning Award are a few of the testaments to the success of this program.

PREPARED STATEMENT OF JOY G. DRYFOOS, HASTINGS-ON-HUDSON, NY, INDEPENDENT RESEARCHER, AND AUTHOR

What do we mean by "adolescents-at-risk"?

The American public has been heavily exposed to the phrase "adolescents at risk". This is a kind of catch-all expression in response to the rising rates of "new morbidities", another phrase that refers to the deliterious consequences of teen sex, drugs and violence. I plead guilty to using this jargon to synthesize and quantify the current status of American Youth. My work has involved studying the "states-of-the-art" in four diverse fields: delinquency, substance abuse, teen pregnancy and school failure/dropout.[1] I have tried to extract meaningful common themes from these separate domains and to translate the findings of research into usable information for policy-makers and the general public.

My estimates are that one in four young people in the U.S. are "at risk" of not growing up into responsible productive adults who can parent effectively, enter the labor force and participate in the political process. These seven million boys and girls (aged 10-17) do it all: they act out at early ages, are behind in school, often truant or suspended, and start using illegal substances before their teen years. In this group of young people, many (1.7 million) will be arrested during a year and more than half will have had sexual intercourse without using any protection against pregnancy or sexually transmitted diseases (STD).

Who is at risk of what?

No matter what field of behavioral research, repeated studies show the characteristics of high risk youth are the same:

* Children who start any high risk behavior at an early age are much more prone to initiate other high risk behaviors. For example, aggressive pre-schoolers are more likely to be delinquent when they get older.

* High risk children lack parental support and nurturing. Children with authoritative parents do well in all domains, as compared to children with authoritarian or permissive parents. It is not the number of parents, it is the quality: One effective parent is better than two ineffective ones.

* Low school achievement and low expectations for success are common to these children. Those who are two years behind their age peers in school (indicating frequency of being left back) rarely complete high school.

* High risk teens cannot resist peer influences. They are easily swayed.

* Living in a disadvantaged inner city neighborhood or remote rural area creates an additional barrier to successful and healthy development.

The "conventional wisdom" is that all "adolescents at risk" are African-American or Hispanic. Actually, about half are white non-Hispanic youngsters, but because of the high incidence of poverty and its association with risk variables, the rates among minority groups are higher. HIV rates are dramatically elevated among African-American and Hispanic youth in inner cities, reflecting the crack epidemic and the absence of treatment facilities. Deaths from drunk driving are significantly higher among young white males, reflecting the heavy alcohol abuse rate in

that group and the absence or non-enforcement of laws about alcohol sales and sobriety tests for drivers.

In my view, we know a lot about who is at risk of what. Teachers report that they can identify children in the earliest grades who are already in trouble. In any given community, it should not be difficult to find schools where substantial proportions of the students are behind grade, a strong predictor of future failure. I believe that these high risk young people will not be able to make it unless immediate and intensive attention is given to their situations. They live in high risk communities and go to high risk schools, and our efforts should be directed toward changing those institutions, rather than focusing solely on individual behavior.

Another 25 percent of our nation's young people are involved in high risk activities, but they are more likely to be "experimentors". Having initiated early substance use or sexual activity makes them vulnerable to behaviors with more dangerous consequences.They need help with decision-making and social skills as well as access to counseling and health services.

About half of all children growing up in the U.S. are doing pretty well...they are not currently at risk of the consequences of sex, drugs or violence, and they are progressing at a reasonable rate in school. At the other end of the social scale from disadvantaged children, they generally enjoy supportive parents and healthy communities. However, they need to be educated about behavioral risks, also need the skills for negotiating with peers and parents, and most of all, no matter what their situation, need

access to excellent schools.

It should be noted that some children growing up in very high risk environments manage to overcome the odds and "make it". However, these "invulnerable" or "resilient" young people almost always have the consistent support of a responsible adult, if not their own parents, than someone else.

What can we do to prevent children from failing to achieve healthy development?

Our understanding of the common characteristics of high risk children, families and communities should shape the guidelines for interventions that are needed to change the life trajectories for "high risk" children. Thus, programs to prevent negative consequences from the "new morbidities" should be: early, involve parents, focus on the acquisition of basic educational skills, deal with peer influences, and concentrate resources in disadvantaged communities.

I believe that there are many programs currently operating in the United States that utilize these concepts and are successful at changing the outcomes for many children. However, this knowledge of "what works" needs to surface to greatly expand the social response to children's issues. Instead, there appears to be a perpetuation of the myth that "nothing works", that spending public funds on social programs is "throwing good money after bad" and that no one knows what to do about sex, drugs, violence and school failure.

I recently reviewed the four unique prevention fields

(delinquency, substance abuse, teen pregnancy, school failure/dropout) and identified 100 programs that could demonstrate positive effects on the behavior of participants. These successful programs probably represent thousands of similar efforts that have not been evaluated. The important point is that no matter what behavioral domain was being addressed, the underlying principles were similar, and in keeping with the concepts described above. The most successful programs appeared to be focused on the underlying problems of youth, rather than simply the categorical behaviors such as using substances, being involved in precocious sexual behavior or being truant:

Early intervention: Head Start programs not only improve the outcomes for little children, the effects last through high school. The theory is that pre-school training helps children get on the achievement track in the early elementary years and that protects them from early initiation of drugs, sex, truancy as well as school failure.

Parent involvement: Home visiting, especially in the early parenting years, is one of the most effective mechanisms for helping families of high risk children. Many disadvantaged parents are afraid to visit schools, or do not know how to negotiate with school or social agency personnel. Parents will come to schools if they are offered jobs as parent aides, or invited to participate at the decision-making level in school reform. Parent workshops are poorly attended by non-supportive parents.

One-on-one individual attention: Almost every successful program includes some form of individual mentoring, tutoring or

personal counseling by community aides, psychologists, nurses, teachers, social workers or case managers. The attachment of a responsible adult to a child or teenager helps support the whole family in dealing with their many problems.

Schools as the focal point: A whole array of interventions to prevent high risk behaviors take place in schools. Obviously, teaching basic skills is the bottom line. There are many successful educational methods including cooperative learning and team teaching as well as the elimination of tracking and suspension. But many other kinds of prevention programs are located in schools including sexuality and family life education; suicide, substance use and violence prevention curricula; school climate initiatives; intensive counseling; school-based health and mental health centers; volunteer community service and job training. Most of the non-educational school-based efforts are designed, operated and funded by outside agencies such as health departments, universities or foundations.

Dealing with peer influences: Social skills training in various forms has proven effective at helping young people become more socially competent, make decisions, communicate with peers and parents, and cope with the complexities of modern living. Training peers to teach social skills curricula has shown some success as have booster sessions over a period of years. One program that hired high risk adolescents to tutor younger children worked well for both groups. However, there is little research documenting the effectiveness of peer counseling programs except to suggest that most of the benefit accrues to the counselors rather than to the

counseless.

Community-based multi-component programs: No one intervention is strong enough to change the environment for young people. The effects of programs are greatly enhanced when a number agencies work together in consort. In the substance abuse field, a community wide health promotion campaign used local media and community education in conjunction with the implementation of substance abuse prevention curricula in the local schools. In the delinquency prevention field, a neighborhood development program involved local residents in councils, working with the schools, police, courts, gang leaders and the media.

A successful model in pregnancy prevention concentrated on community education through the media and a speakers' bureau, training of parents, clergy and other community leaders, along with the development and implementation of comprehensive sex education in the schools. The problem of school dropout was addressed by an all-out community effort that involved the schools with local businesses, local governmental agencies and universities in planning, teacher training and job placement of students.

Implications of these findings for Select Committee

We know a great deal about "the risky business of adolescence"; the absence of social response to the dire situation facing many young people cannot be attributed to a shortage of research. We know how to "help teens stay safe"; we have a reasonably good handle on what works to prevent high risk behaviors. So why does our nation continue to generate evidence of

the highest teenage morbitity rates among western nations? I believe we are lacking the necessary level of commitment required to develop the intensive, massive movement that will change the life trajectories for millions of children and their families. We are unwilling to implement on a large scale the program components that must go into the package.

My vision of the future calls for the development of new institutions called Community Schools, central places that bring together the movement for quality schools with the provision of support and health services from the community. I didn't invent this phrase, in fact, many reports echo this appeal such as those recently issued by the Office of Technology Assessment[2], the American Medical Association and the National State Boards of Education[3], and the Committee for Economic Development [4]. Certain states have taken the leadership in this emerging field by creating state grants to communities to develop school-based youth service centers or family resource centers. New Jersey, Kentucky, Oregon, Florida, and Michigan each have different approaches to building these new kinds of institutional arrangements. Several bills have been introduced into Congress already, and the Young Americans Act has been passed (but not funded) that call for support for such entities.

The concept centers around "one-stop-shopping", co-location of child and family services in or next door to a school so that there can be integration of in-school experience with needed services. Many diverse school-based models exist around the country which include one or more of the following: health services, mental

health counseling, substance abuse treatment, family planning services, child care, parent education, job preparation and placement, after-school mentoring, recreation, sports and family social and cultural events. Individual counseling and crisis intervention are common to almost all of these units. In truth, almost any existing service can be located within a school area, thus creating a rationally designed new institution that integrates the various necessary pieces of the package. Often, case management is used as the mechanism for tracking children and their families, helping them identify what services they need, and acting as intermediaries between the family, the school and other community agencies.

I urge the Select Committee to consider how to reshape the federal government to be more responsive to the complete needs of high risk children, and not just to continue to address their categorical parts. We must develop large-scale immediate intensive interventions, organized so that children are assured continuous attention and not allowed to slip through the cracks. The potential loss of one fourth of our children from the future pool of effective adults represents a crisis of extraordinary dimensions, a crisis which Congress and the American people can no longer ignore.

Notes

1.Dryfoos, J. Adolescents-at-Risk: Prevalence and Prevention, York, Oxford Press, 1990.

2.U.S. Congress, Office of Technology Assessment, Adoles Health-Volume I: Summary and Policy Options, OTA-H-4687. Washin DC: USGPO, April, 1991

3.National Commission on the Role fo the School and the Commu in Improving Adolescent Health, Code Blue: Uniting for Healt Youth. Washington: National Association of State Boards Education, 1990.

4. Committee for Economic Development, The Unfinished Agenda: A Vision for Child Development and Education, Washington: Commi for Economic Development, 1991.

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
WASHINGTON, DC 20515-6401

June 27, 1991

Lloyd Kolbe, Ph.D., Director
Division of Adolescent and School Health
Center for Chronic Disease Prevention and
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Centers for Disease Control
1600 Clifton Road
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Dear Dr. Kolbe:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "The Risky Business of Adolescence: How to Help Teens Stay Safe," Part I, June 17, 1991. Your testimony was important to the work of the Committee.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript by July 11 with any necessary corrections.

In addition, Representative Frank Wolf, Ranking Minority Member, has requested that you furnuish the following information for the record

1. Please submit any and all reports concerning the failure rate of condoms in general and for teens in particular.

2. Please submit any and all reports or studies concerning the failure rate of condoms in relation to sexually transmitted diseases, in particular AIDs transmission.

3. Given the five recent cases of AIDs being transmitted by a dentist in Florida, is the Centers for Disease Control (CDC) issuing any new guidelines or recommendations on the transmission of AIDs?

4. What are the CDC's advisories regarding sexual contact with a known HIV positive individual? Have any studies by the CDC or other health institutions that you know of been discontinued because of the high rate of transmission among HIV positive individuals despite the use of condoms?

Sincerely,

PATRICIA SCHROEDER
Chairwoman
Select Committee on Children,
Youth and Families

Enclosure

Response From Lloyd Kolbe, Ph.D., to Questions Posed by Congressman Frank Wolf

Questions: Please submit any and all reports or studies concerning the failure rate of condoms in general and for teens in particular. Please submit any and all reports or studies concerning the failure rate of condoms in relation to sexually transmitted diseases, in particular, AIDS transmission.

Answer: Because these two questions are similar, we are providing one response as follows. Studies about the efficacy of condoms have been reviewed in the two enclosed Centers for Disease Control (CDC) articles. The article enclosed as Appendix One, "Condoms for Prevention of Sexually Transmitted Diseases," was published in the Morbidity and Mortality Weekly Report, March 11, 1988. The article enclosed as Appendix Two, "Reproductive Tract Infections and Contraceptive Use/Safety," has been submitted for publication. A summary of these two articles follows; and a list of important studies referenced is enclosed as Appendix Three. In addition, a special issue of Population Reports, prepared at Johns Hopkins University with support from the U.S. Agency for International Development, "Condoms - Now More Than Ever", is enclosed as Appendix Four.

Condoms provide a mechanical barrier which prevents direct contact with semen, genital discharge, genital lesions, and infectious secretions. When condoms are used consistently and correctly, they are extremely effective in preventing sexually transmitted diseases (STD). Effectiveness of condoms to prevent STDs has been documented in many laboratory and clinical studies.

Multiple laboratory studies, some of which attempted to simulate the mechanical friction of coitus, have clearly demonstrated that an intact latex condom is a continuous, effective barrier to sexually transmitted bacteria and viruses, including HIV. In laboratory tests natural membrane ("skin") condoms, however, have been shown to contain small pores which allow passage of HIV and smaller viruses such as hepatitis B virus.

Multiple studies conducted among sexually active persons have shown that condoms reduce the risk to users and their partners of infection with gonorrhea, ureaplasma, herpes simplex virus, and HIV. As with contraceptive studies, effectiveness varies among studies. Several studies show 100% effectiveness, but others show that some individuals became infected despite self-reported condom use. Some of these individuals may have become infected because of inconsistent condom use. Condom failure is due to nonuse, inconsistent use, incorrect use, breakage, or leakage. Although the "typical" failure rate of condoms as contraceptives is approximately 10-20%, this figure reflects failure of the user (to use the condom) in addition to failure of the condom itself. Indeed, condom effectiveness as a contraceptive increases with experience, and failure rates as low as 0.6% have been documented (Vessey). Most data suggest that nonuse, inconsistent use, and incorrect use, not condom breakage or leakage, is usually responsible for infections and unwanted

pregnancies. Inconsistent use alone accounts for a large proportion of unwanted pregnancies among condom users (Sophocles). For example, studies in Bangladesh (Ahmed 1990), and Barbados (Russell-Brown) showed that only 60% and 30%, respectively, of men who said they used condoms for contraception actually used them for every act of intercourse.

Incorrect use also accounts for some condom failures and breakage. In one study, men who acquired gonorrhea despite condom use reported putting the condom on the penis after sexual activity had begun (Darrow). Most studies in the United States have shown breakage rates are less than 1 break per 100 acts of intercourse, and incorrect use accounts for a large proportion of the breaks. One Australian study (Richters) reported 8 breaks in 1269 acts of vaginal and anal sex (a rate of 0.6%); seven of the breaks were related to fingernail tears or use of oil-based lubricant (which weakens the latex).

Manufacturing defects are quite uncommon, since national standards are used and samples are tested to assure high quality. Each condom is individually electronically tested for pinholes or areas of thinning as a part of manufacturing quality control in the United States. Moreover, condoms are classified as medical devices by the Food and Drug Administration (FDA). All domestic and imported batches of condoms are subject to sampling and testing by FDA. Batches which fail are not allowed to be sold in the United States. It is important to remember that a broken condom does not always lead to pregnancy or infection (Liskin). A woman's chances of pregnancy from a single act of intercourse have been estimated to average 2-4% (Tietze). In one U.S. survey, pregnancy occurred in only 4% of women who reported condom breakage (Hatcher). The chances of infection with HIV after a single sexual exposure has been estimated to be as low as 0.001 and as high as 0.1 (Liskin). Also, not all condom breaks are equally risky. In one study (Piedrahita), more than half of the breaks occurred while the condom was being put on or taken off. In another study, all breaks occurred prior to ejaculation (Richters).

In summary, we regard condom use as "highly effective" for the following reasons: (1) intact latex condoms are an effective barrier against bacteria and viruses, (2) multiple studies have demonstrated that condom use protects against sexually transmitted diseases, (3) several studies have shown that persons exposed to HIV who used condoms remained free of infection over many months, (4) extremely low contraceptive failure rates have been demonstrated among experienced condom users, and (5) condoms are manufactured with high standards of quality. The individual user, not the condom, is more likely to be responsible for any failure in protection from sexually transmitted infections as well as unwanted pregnancies.

Question: Given the five recent cases of AIDS being transmitted by a dentist in Florida, is the CDC issuing any new guidelines or recommendations on the transmission of AIDS?

Answer: During the past year, CDC has been reviewing the existing guidelines for health care workers and determining the need for any additional recommendations and guidelines to prevent transmission of human immunodeficiency virus (HIV) and hepatitis B virus (HBV) from health care workers to patients during invasive medical and dental procedures.

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[Appendix One, article entitled: "Condoms for Prevention of Sexually Transmitted Diseases", reprinted by the U.S. Department of Health and Human Services, Public Health Service, from MMWR, March 11, 1988, Vol. 37, No. 9, pp. 133-137, is retained in committee files]

[Appendix Two, article entitled: "Reproductive Tract Infections and Contraceptive Use/Safety", Department of Health and Human Services, U.S. Public Health Service, Centers for Disease Control, Center for Prevention Services, Division of STD/HIV Prevention, Atlanta, GA, is retained in committee files]

[Appendix Four, article entitled: "Condoms—Now More Than Ever", from Population Reports, Series H, Number 8, September 1990, are retained in committee files]

Following a meeting with consultants and representatives of the medical, public health, and scientific communities, professional and service organizations, federal agencies, and the public held in August 1990, CDC developed a preliminary draft of these guidelines. During February 21-22, 1991, CDC held an open public meeting to discuss this draft and to solicit comments regarding its contents. The revised guidelines were released on July 15 as a special issue of the Morbidity and Mortality Weekly Report: Recommendations and Reports (MMWR-RR).

Question: What are the CDC's advisories regarding sexual contact with a known HIV positive individual? Have any studies by the CDC or other health institutions that you know of been discontinued because of the high rate of transmission among HIV positive individuals despite the use of condoms?

Answer: The CDC's advice regarding sexual contact with a known HIV positive individual is consistent with the 1986 Surgeon General's Report on AIDS, e.g., to always use a condom. This recommendation is routinely provided through CDC's National AIDS Hotlines and by CDC-support HIV prevention staff nationwide.

The CDC is unaware of any studies that have been discontinued because of the high rate of HIV transmission from infected individuals who report condom use. On the contrary, studies indicate that correct and consistent use of latex condoms provides an effective (although not 100% effective) barrier to prevent transmission of HIV infection and other sexually transmitted diseases. As has been discussed earlier, data suggest that the individual user, not the condom, is more likely to be responsible for any failure in protection from sexually transmitted infections as well as unwanted pregnancies.

Appendix Three

Important References

Review Articles

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U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
WASHINGTON, DC 20515-6401

June 27, 1991

Kathleen M. Sullivan, Director
Project Respect
P.O. Box 97
Golf, IL 60029-0097

Dear Ms. Sullivan:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "The Risky Business of Adolescence: How to Help Teens Stay Safe," Part I, June 17, 1991. Your testimony was important to the work of the Committee.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript by July 11 with any necessary corrections.

In addition, Representative Frank Wolf, Ranking Minority Member has requested that you furnish the committee the following items:

1. All reports you referred to on condom failure and the information that you recommend providing students on condom failure.

2. Any reports or evaluations on Project Respect.

Sincerely,

PATRICIA SCHROEDER
Chairwoman
Select Committee on Children,
Youth and Families

Enclosure

FAILURE RATE OF CONTRACEPTIVES

Two studies reveal the annual in-use failure rate for contraceptives:

- ***The Pill 11%**
- ***Diaphram ..... Close to 32%**
- ***IUD ..... Almost 11%**
- ***Condoms ..... 18%+**
- ***Creams, Jellies, Foams .....up to 34%**

Ref: Researchers Mark D. Hayward and Junichi Yagi, "Contraceptive Failure in the United States: Estimates from the 1982 National Survey of Family Growth," *Family Planning Perspectives*: Sept/Oct., 1986, Table 3. Researchers Melvin Zelnik, Michael A. K Koenig, and Kim Young, "Sources of Prescription Contraceptives and Subsequent Pregnancy Among Young Women," *Family Planning Perspectives*: Jan/Feb., 1984.

When 1st year failure rates are extrapolated, *i.e.*, estimated, over extended intervals using the binomial probability formula, the following chances for pregnancy are found:

- ***A fourteen-year-old girl faithfully using the pill has a 44% chance of getting pregnant at least once before she finishes high school.**
- ***She has a 69% chance of getting pregnant at least once before she finishes college.**
- ***She has a 30% chance of getting pregnant two or more times.**
- ***Using condoms, the likelihood of unwanted pregnancy while she is in school rises to nearly 87%.**

Ref: Grant, George, *Grand Illusions*, Wolgemuth & Hyatt Publishes, Inc.: Brentwood, TN, 1988, p. 30.

Contraceptive sex education exacerbates the adolescent pregnancy problem.

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PROJECT
RESPECT

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Director: Kathleen M. Sullivan

FINAL REPORT
Office of Adolescent Pregnancy Programs
#000816
Title XX
1985-1990

Performance Report
Summary

Project Respect
A Division of
The Committee on the Status of Women

(708) 729-3298 or 3308

INTRODUCTION

The Committee on the Status of Women was awarded a three year grant, beginning in October 1985, to develop a text that would portray the straight abstinence message and to direct a pilot test of that text in middle grades of public schools in six midwest states. After three years, an additional two-year extension was granted to permit a "Follow-up" of the students in the pilot schools and to permit each school to partake for a three year period.

The basic question examined in this pilot project was whether adolescents would be receptive to and affected by a clear and unambiguous message about abstinence. Examination of the data collected in this five-year study indicates a consistent attitudinal improvement in favor of abstinence by students taking Sex Respect: The Option of True Sexual Freedom. Even more encouraging was the evidence of a positive and significant difference in sexual behavior between program versus non-program students, one year and even two years after program completion.

HISTORY AND DESCRIPTION OF PROJECT

The history of this grant shows that during the first half of year one, the manuscript for Sex Respect: The Option of True Sexual Freedom was completed and submitted for the review process by O.A.P.P. Certain revisions were required and this was completed in early January, 1986, which facilitated printing of the text by February, 1986, at which time implementation was started in the first of five schools for the spring of 1986 with 1300 students. In the second year, ten schools were added (total 2,500 students), and the third year, eleven were added (5,600 students). In most cases, these were schools which came to us and asked to participate having heard about the pilot opportunity. At the end of the third year, an extension was granted to permit each school to participate for a minimum of three years and to conduct a follow-up survey to be administered to the students at one and two years away from when they participated in the Sex-Respect classroom course. This follow-up was to ascertain if there was a long lasting impact on their attitudes and/or their behavior.

Sex Respect: The Option of True Sexual Freedom is a ten-unit text used to present teens with cogent reasons for sexual abstinence against a background of respect for sexual powers as good and enriching to each individual and society in general. The decision to publish in three separate books proved to be advantageous. Besides the Student Workbook, there is a Parent Guide. This is sent home and provides the parents with a tool to follow the students' classroom experience and build communication with them, thus eliminating controversy and building parental involvement. The third book, a Teacher Manual, is very "user friendly," as it provides the teacher with a duplicate of the student text as well as 44 pages of teaching guidelines interwoven for each chapter.

The originators of this unique curriculum believed that teenagers receive little support outside family for the idea of postponing sexual relations through the practice of self-restraint. In many high schools today, the perception is that promiscuity is practically promoted and the resultant, out-of-wedlock childbearing is increasing at an alarming rate, as are gonorrhea, syphilis, AIDS and other new forms of venereal diseases.

Emphasis of Sex Respect: The Option of True Sexual Freedom is the overall health of the adolescent, both male and female, not just as a solution to teen pregnancy. In approaching the issue in this general manner, stressing the emotional as well as physical and psychological problems of adolescents being sexually active, has proven to attract the interest of males in a significant manner. In analyzing the response to questions 17, 18, 19, and 25, males show as great a movement as females (see attached graphs pages 16 and 17). The male improvement however was greater in the final years. This is an interesting point for further study. Are young males today more open to the abstinence message than five years ago because of disease and emotional factors?

Most other teen pregnancy prevention programs concentrate on the birth control factor and, in the past two years (1989-90), most particularly on condom use. They give the "perception of despair" that students are eventually going to get sexually involved and they concentrate on "damage control" rather than attacking the root cause. They have an attitude of pessimism as to the control of emotions and behavior. Sex Respect: The Option of True Sexual Freedom, on the other hand, assumes that all teens, given the right support, rationale, and motivation, have a greater than equal chance at maintaining sexual abstinence and the vast majority of adolescents are in this category. Our findings proved this clearly in the statistics to Question 13, 18 and 19 example of fifth year statistics.

13. Do you think sexual urges are controllable?

	Pre Test %	Post Test %
A. Always	28	48
B. Never	4	4
C. Sometimes	51	40
D. Don't know	17	8

18. The best way for young people to avoid an unwanted pregnancy is to wait until they are married before having sex.

	Pre Test %	Post Test %	
A. Strongly agree	43	59	89%
B. Agree	36	29	
C. Not sure	12	7	
D. Disagree	9	4	

79%

19. The best way for young people to keep from getting AIDS or some other sexually transmitted disease is to wait until they are married before having sex.

	Pre Test %	Post Test %	
A. Strongly agree	37	55	85%
B. Agree	28	30	
C. Not sure	16	9	
D. Disagree	19	6	

65%

229

It is also important to note the very low number in question 13, "Do you think sexual urges are controllable," that reply "NEVER," 4% pre and post. This indicates that adolescents do know these are emotions that can be controlled. What they need to understand is why they ought to be controlled and how to control these emotions.

Among innovative features of Sex Respect: The Option of True Sexual Freedom, the chief one is its how and why to "say NO" character. Another feature is the enumerating of techniques for dealing with pressure from peers to engage in sexual relations. A third is providing a rationale -- a set of convincing reasons -- for postponing sexual relations. A fourth is offering emotional and intellectual support to counter the peer pressure encouraging sexual activity. Statistics of Question 11 & 20 show:

11. Dating in mixed groups is less likely to lead to sexual activity?

	Pre Test %	Post Test %
A. Strongly agree	11	28
B. Agree	33	40
C. Somewhat agree	40	20
D. Disagree	15	11

20. In a relationship between a boy and a girl, there are many things that are much more important than sex.

	Pre Test %	Post Test %
A. Strongly agree	49	59
B. Agree	39	31
C. Not sure	0	0
D. Disagree	4	3
E. No response	0	0

224

230

FINDING AND OUTCOMES

There are many interesting observations to be made from the statistics gathered over the course of this pilot study. Particularly, the results of the Follow-up analysis as shown on graphs at the end of the evaluation report for the fifth year. Even though funding was limited for evaluation purposes, we wish to point out some of the areas that seem significant from observing the raw data and suggest further study in these areas might be very beneficial.

One such example are answers to questions 9 and 10.

9. Have you been taught about puberty and the physical changes that happen when young people develop sexually?

	1988		1989		1990	
	Pre %	Post %	Pre %	Post %	Pre %	Post %
A. Yes	92	96	94	94	92	96
B. No	6	3	5	2	8	4
C. No response	2	1	1	4		

10. If the above answer is yes, did your information come from: (more than one may be checked)?

	1988		1989		1990	
	Pre %	Post %	Pre %	Post %	Pre %	Post %
A. Your parents	55	55	52	52	61	58
B. Church or synagogue	4	5	6	7	7	6
C. School	58	92	54	67	49	67
D. TV, radio, or movies	14	16	16	17	15	15
E. Other	18	19	17	19	15	17
F. No response	5	1	5	5	7	2

There are two very significant statistics to observe from our pre and post test:

A. Adolescents perceive their information about sexual development is coming approximately equal from parents and school (NOTE pre test)
B. Adolescents perceive "church or synagogue" as a very minor source of information (4 to 7%).

Since it is often heard that sexuality/mortality is an area for the churches to handle, these statistics indicate a great void in our adolescents' impression that the churches are providing it.

Another interesting question to study over a period of time is question 21.

21. Do you feel that sex among unmarried teens is?

	1988		1989		1990	
	Pre %	Post %	Pre %	Post %	Pre %	Post %
A. Very wrong	20	29	21	30	33	41
B. Quite wrong	24	30	28	33	32	35
C. Not very wrong	37	30	34	26	26	17
D. Not at all wrong	17	10	13	9	8	6
E. No response	2	2	2	1	2	1

These improved answers over the 3 year period could indicate the adolescents more recent acceptance of directive versus non-directive approaches in the sexual area as well as the drug. Clearly stating that adolescent sexual activity is WRONG, just as is done for substance abuse, could help to clarify the issue in the students' minds and give the "direction" needed for young people.

A very thought-provoking section in the Sex Respect text is the reference to and discussion of "secondary virginity." The results were positive, as seen in data from question 32, and the movement within groups deserves much more in depth analysis.

32. A teen who has had sex outside of marriage would benefit by deciding to stop having sex and wait for marriage.

	1988			1989			1990		
	Pre %	Post %		Pre %	Post %		Pre %	Post %	
A. Absolutely true	17	33	57%	21	37	61%	28	44	69%
B. Very true	19	24		20	24		21	25	
C. Somewhat true	47	33		46	32		40	26	
D. Not true at all	14	8		11	6		10	5	
E. No response	3	2		2	1				

Another question that warrants further analyzing could be question 33 which shows the strong desire of teens to share with parents. This is contrary to the prevalent impression of society today. All years showed that a consistent 76 - 77% felt it was "very important" and another 17% "somewhat important" (total 93 - 96%) in their answers to the question: "If you were unmarried and pregnant or had gotten someone pregnant, how important would it be to share this problem with your parents?"

This grant to develop and pilot test the Sex Respect: The Option of True Sexual Freedom curriculum has truly demonstrated that adolescents will be receptive to the "straight abstinence" message and that it does affect their attitudes and behavior.

FOLLOW-UP

As part of the grant award from O.A.P.P. for the fourth and fifth year, Project Respect conducted a Follow-up questionaire among students who had participated in the Sex Respect classroom presentation one year prior and two years prior. This was to determine if the curriculum had a lasting effect on their attitude and whether it had an effect on their actions regarding sexual activity. This new questionaire also included "action" questions regarding alcohol and drug use to determine if there was a correlation between these three items.

The data indicates a definite correlation showing that those adolescents who are involved in one are usually involved in two or all three. The greatest (and apparent first) involvement is alcohol. Graphs on pages 28 and 29 of the evaluation report show clearly the involvement.

The most significant findings of the evaluation was that students who participated in the pilot study using Sex Respect: The Option of True Sexual Freedom text had far less pregnancies than the control group. Among females, it was 5% both one and two years away from participation compared to 9% for non-program students (national norm is 10%). For males, it was 4% for one year and 5% for those two years away from participation, compared to 7% for non-program students (see attached figure 7, page 23). Lower male statistics are due to the fact that males are not always aware that they have caused a pregnancy.

Findings from the Follow-up analysis seem to indicate a definite lasting effect. However, a good case can be made for reinforcement of a school program at higher grades.

The change in attitude was recognized early in the grant period (within the first year) as schools and individual groups started asking for information and purchasing the text to use on their own. As interest grew, it became evident that "teaching tools" in this area were in great demand, though the supply is still rather limited. Also needed is general community support for promoting abstinence.

The emotional, as well as physical, health of our young people is affected if they are sexually active; not just from the pregnancy risk for the girls, but from the numerous other problems evident today. **Adolescents are the one group that can be removed from the "at risk" category of AIDS if they are convinced to avoid drugs and/or sexual activity.**

Funding from other sources for implementation of this curriculum, that we are aware of, has been forthcoming from a variety of sources in different parts of the country (I.e., The Junior League in two large communities, Community Chest in East St. Louis, The March of Dimes in a town in Iowa). State and local public funding has been substantial in certain areas, including the State of Illinois where currently, for the 1990-1991 school year, 70 schools totaling 14,000 students, are participating in a pilot study directed by Project Respect. It is estimated that 1,600 schools nationwide and in several foreign countries now use this text which indicates it is established as an ongoing program.

Project Respect has developed and published a new senior high school curriculum, Facing Reality. This will fulfill the need for a reinforcement of the abstinence message at the higher grade level. Analysis of our evaluations of the Follow-up showed that a composite approach, abstinence to drugs, alcohol and sexual activity, was needed as most adolescents involved in one, were involved in two or all three. Project Respect has received a grant for conducting a longitudinal study utilizing FACING REALITY, to show if the two tier exposure to abstinence education does have an impact on attitude and behavior over a period of time.

There have also been other texts, videos, audio tapes, booklets and pamphlets produced during the five years by Project Respect and others to fill the need for teaching in this vital area.

Figure 9. Alcohol use and sexual activity rates

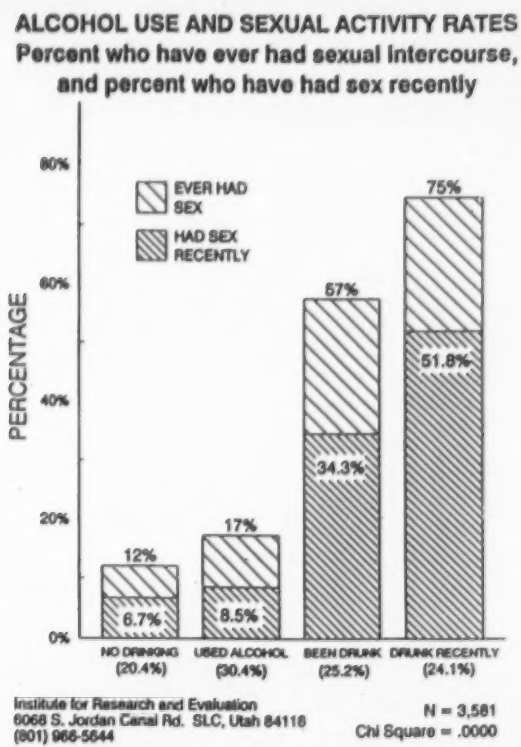


Figure 10. Drug use and sexual activity rates

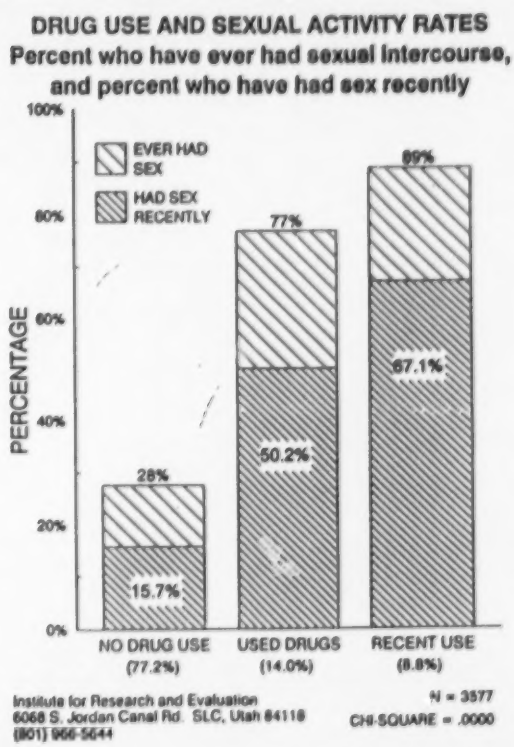


Figure 1. Male and female comparisons on item 17.

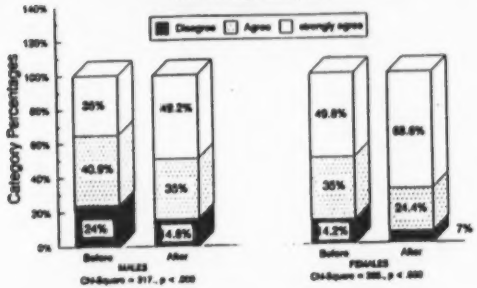


Figure 2. Male and female comparisons on Item 18.

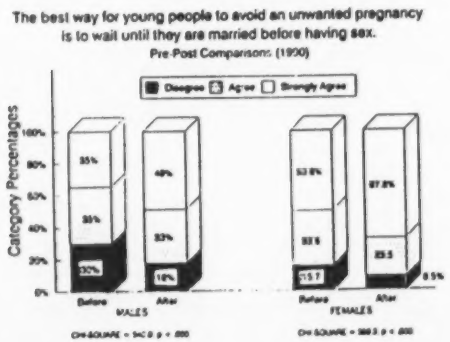


Figure 3. male and female comparisons on Item 19.

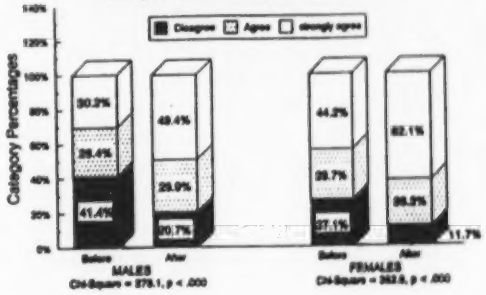
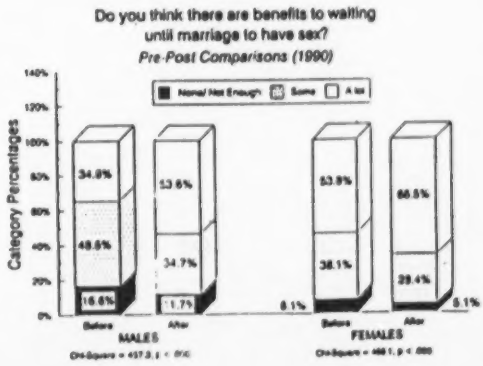


Figure 4. Male and female comparisons on item 25.



EVALUATION REPORT ILLINOIS SCHOOLS

SEX RESPECT

1989-1990

Prepared by

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Submitted for Third Year Pilot Test

Conducted By:

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PROJECT
RESPECT

P.O. Box 97
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Director: Kathleen M. Sullivan

The Sex Respect Pilot Program

Project Respect has been funded by the Office of Adolescent Pregnancy Programs of the U.S. Department of Health and Human Services under Title XX.

Beginning in September, 1985, The Committee on the Status of Women received the above grant and began developing and testing the curriculum, Sex Respect, based on the single message of abstinence as the best means to remove adolescents from the "at-risk" category for AIDS and to reduce teen pregnancy.

The results of our five years of evaluations of students in the course clearly show that teaching abstinence is well received among today's adolescents.

All of the schools who have participated in the five-year federal pilot study, as well as forty-six Illinois funded pilot schools, have shown positive results. The federal schools have been from six midwestern states and from various socio-economic backgrounds.

In these last two years of our five year study, a follow-up questionnaire was administered to students who took the course one and two years prior. These results show sustained attitudes and actions.

INTRODUCTION

Project Respect's final composite report of the SEX RESPECT curriculum's pilot testing, in Illinois schools for 1989-1990, which was funded by Illinois Department of Public Aid (Contract #90G81087) and Illinois Department of Public Health (Contract #9947812192), has again shown positive attitudinal improvement.

The implementation of this abstinence program, mainly in grades eight through ten, provided student workbooks and parent guidebooks for 7,269 students in 46 schools under said contracts.

Administration of a pre-questionnaire prior to the start and a post-questionnaire at the close of the ten unit course was required. Student anonymity was guaranteed through assigning each student a number and matching the pre and post tests to show specific movement in attitudes.

An eagerness, involvement and support for the abstinence curriculum has been shown by parents and echoed in the improved attitudes of the students.

Requests continue from additional schools to become part of our pilot program and appreciative responses have been received from the 1989-1990 schools at their evaluation results.

Applications for the 1990-1991 school year total 68.

SEX RESPECT: EVALUATION REPORT 1989 - 1990

OBJECTIVES

The Sex Respect Education Program is designed to address the problem of premarital sexual activity and the consequences of pregnancy, abortion, sexually transmitted diseases, etc. occurring among today's teens. The program encourages an attitude of respect for human sexuality and emphasizes abstinence as an appropriate way to prevent pregnancy childbearing and sexually transmitted diseases among teenagers while encouraging the supporting values and attitudes which facilitate abstinence.

The following are primary objectives of the Sex Respect program:

1. To improve awareness and recognition of the potentially harmful consequences of early sexual activity.

2. To increase adherence to attitudes and values supporting abstinence from sexual relations among teenagers.

3. To increase the willingness and motivation of teenagers to delay or avoid early sexual activity.

4.To improve the skills which help teenagers resist pressure to be sexually involved.

5. To increase moral and social support from peers, family and the community for teenagers who refrain from sexual relations.

6. To help create a counter-peer pressure on behalf of self restraint by helping students to internalize cogent reasons for self restraint and abstinence.

7. To infuse the regular health education programs for young adolescents with a greater emphasis on "say no" to risky and potentially harmful behaviors, including early sexual activity.

8. To more broadly disseminate information to promote sex respect and sexual self restraint.

9. To increase parental involvement and the level of interaction between parents and teenagers concerning the value of abstinence and the reasons for sexual self restraint during adolescence.

These objectives are to be accomplished through the administration of classroom instruction, and essentially through publications and other materials made available to schools, libraries and individual students. Achieving these objectives is intended to ultimately produce reductions in teenage sexual activity and pregnancy rates plus substantially helping remove our adolescents from the "at risk" category of AIDS.

EVALUATION MODEL

Evaluation of the Illinois program has primarily focused upon anonymous questionnaires given prior to and immediately following the completion of the classroom instruction component. This is the same program model used for evaluating Project Respect's testing of the Federal program. The Federal pilot test just completed it's fifth year. It has tested twenty six schools in six Midwest states, Educational Regions V and VII during this time span. The Federal pilot program was funded from the Office of Adolescent Pregnancy Programs, a division of the Department of Health & Human Sciences.

The questionnaires were administered before and after the presentation of the Sex Respect curriculum to 7,269 students at 46 Illinois Schools. Four thousand seventy-six illinois students were actually tabulated for analysis. The difference in numbers is due to absenteeism for either pre or post questionnaires, incomplete questionnaires or unmatchable numbers and the inability of teachers to administer the post in the closing days of the school year. Data from questionnaires were entered and have been maintained using DBASE III software on an IBM XT computer at the Project's headquarters. SAS statistical software on a IBM mainframe computer was used for the statistical analysis.

An important advantage of this data is the ability to study individual, rather than just aggregate change. Linked pre- and post- test scores are available for each of the students involved in the program. This allows for better analysis of patterns of change than would be possible if only repeated cross-sectional information were available. The questionnaire was designed to assess changes in sexual attitudes and values among teens occurring as a result of exposure to the Sex Respect program.

METHODOLOGY

The analysis is based primarily on two basic analytic strategies. One is a basic cross-tabulation of pre and post test scores. This allows a description of patterns of movement and change occurring between these two occasions.

The other strategy involves a series of repeated measures t-tests which assess the statistical significance of pre-post differences on these items. In addition to tests for all program participants, separate tests are kept for the various sites where the program was implemented, and for a number of different population subgroups. The results are reported by age, sex, living arrangements, parental education, church attendance, and academic ability. This data includes a standardized measure of effect size (the magnitude of the pre-post difference divided by its standard deviation) as well as the traditional t-test results where these can be meaningfully presented.

In general, t-values greater than 2.0 will be statistically significant. However, with the number of students in the study, even quite small effects will often be statistically significant. Effect size measures in standard deviation units allow an assessment of effect that are not as influenced by the number of observations. Generally, standardized effect sizes of .2 standard deviations are considered essential for an effect to be meaningful. Effect sizes of .3 to .4 are usually considered substantively important, and effects of .5 (half of a standard deviation) and greater are seen as quite a large. Standardized effect size measures are particularly useful when comparing across variables and subgroups. An important objective of this evaluation is to see to what extent observed changes hold up across sites and the various population subgroups.

Reference to the pre-post cross-tabulations will also enable the reader to examine patterns of change in greater detail. Special log-linear models for assessing change were also used, and produced results essentially equivalent to those of the t-tests.

RESULTS

This evaluation is based on data from students involved in the Sex Respect program in forty-six sites throughout the State of Illinois. Schools varied in number of students from approximately 20 to 500. There was a wide variety of socio-economic backgrounds. Some are predominantly black inner city schools and others include a mixture of Hispanic students. There are also a mixture of small and midsize city populations.

Attached are sample graphs showing the movement within certain questions that demonstrate the attitudinal improvement. Also provided are bar graphs to show the improvement within different sub-groups for certain questions. Most notable is the substantial improvement shown on bar graphs for ALL sub-groups. Many are 0.4 (large) to 0.5 and above.

Detailed graphs and specifics are available for each question should your office be interested in a more specific analysis. However, funding was not provided for such a detail in those contracts.

A printout of the results for each school is provided here. These have already been sent to each individual school.

This report of results for Illinois schools is a composite of schools throughout the state which were funded by The Illinois Department of Public Health and The Illinois Department of Public Aid.

The same basic program was used for implementation and evaluation in all the Illinois State funded schools. They all administered the pre/post questionnaires in like manner to facilitate accurate tabulating. The difference between the number of clients served (7,269 students) and the number tabulated (4,076) is due to absenteeism at the time of "pre" or "post," unmatched questionnaires, incomplete questionnaires, and a few classes that did not return questionnaires.

STUDENTS' OVERALL EVALUATION OF THE SEX RESPECT PROGRAM

Students were asked to make a global evaluation of the quality of the Sex Respect program. About three fourths rated it excellent or good and only 6% rated it as poor. It is important to note that this is consistent with the reports of past years. There were some differences in this according to population subgroup but the differences were generally not large.

SEX AND MARRIAGE

There were substantial increases in the perceived benefits of premarital virginity. In today's health crisis, pregnancy is no longer the primary concern. The main problem, now, is that "teenagers have more sexually transmitted diseases then any other group in the United States."* Factoring in the emotional trauma from premarital relations with actual physical disease, teen sexual activity has literally become a matter of life and death.

Before the abstinence program began, 58% of the students agreed or strongly agreed that the best way for young people to keep from getting AIDS or some other sexually transmitted disease is to wait until they are married before having sex. After the program, 80% agreed or strongly agreed. Though the students agreed or strongly agreed (68% before, 84% after) that the best way for young people to avoid unwanted pregnancy is to wait until they are married before having sex; they also considered that even if there is no pregnancy, sexual relations can cause a lot of other problems for unmarried teens (75.5% agreed or strongly agreed before, 88.9% after the course).

The impact is quite broadly based. Younger and older students, males and females, students living with both parents or in other family arrangements, students with poorly educated or highly educated parents, regular church attenders and those who seldom or never attend, and students doing well or poorly in school all showed important changes in the desired direction. The effects are substantial and quite general. Furthermore, this pattern of results was quite similar for the other items measuring program effects on these attitudes and beliefs.

The perceived benefits of "secondary" virginity also showed important increases. Before the program, about 38% felt that teens who had previously had sex would benefit by stopping sexual activity and waiting until marriage (responses "very true" or "absolutely true"). After the program, this had increased to 58%. Again, the effect appears very consistent across the various population subgroups and represents a very general and important effect. This is an increase of 20%.

* California pediatrician, Mary-Ann Shafer of the University of California Medical School in San Francisco.

FAMILY COMMUNICATION

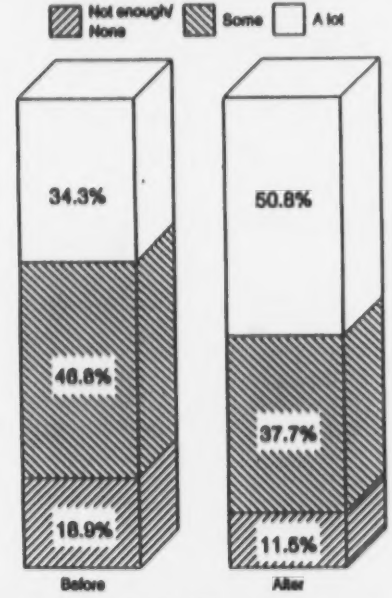
Contrary to the current notion that teens "can't" or "won't" talk to their parents about unwed pregnancy is the high response in category "A" of the following question:

If you were unmarried and pregnant or had gotten someone pregnant, how important would it be to share this problem with your parents?

	Before	After
A. Very Important	78%	79%
B. Somewhat Important	16 (93%)	15 (94%)
C. Not Very Important	3	3
D. Not Important	3	2

NOTE: The high response BEFORE the course, as well as AFTER, negates the perception that teens don't want to communicate with their parents on this topic.

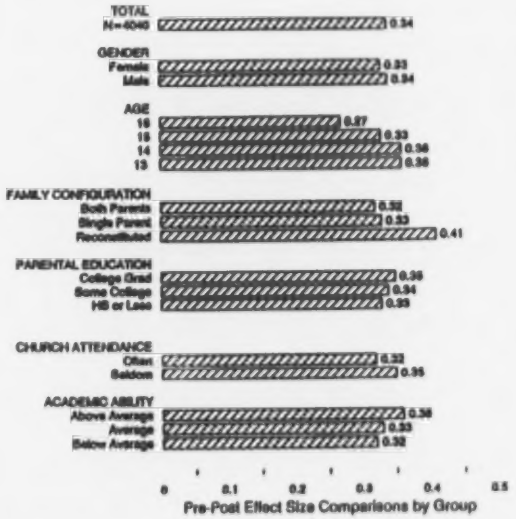
Do you think there are benefits to waiting until marriage to have sex?



n=4,040, t=21.3, p < .0001

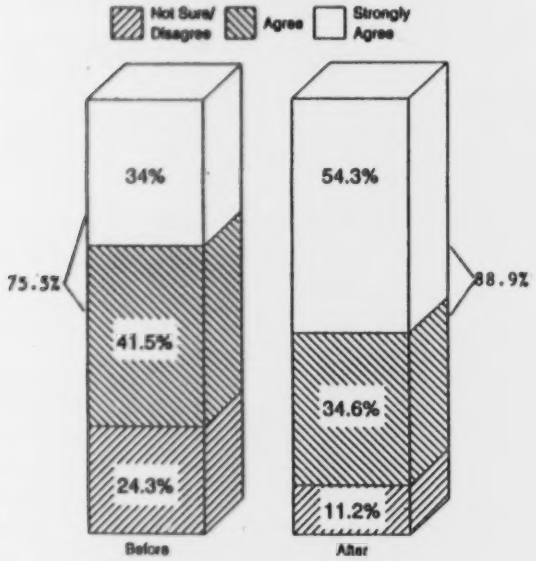
Pre-Post Comparisons (1990 - Illinois Schools)

Do you think there are benefits to waiting until marriage to have sex?



Effect Size .20=significant
.30=large
.40=very large

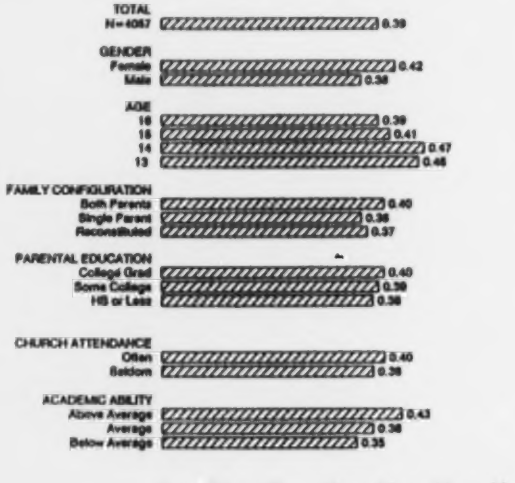
Even if there is no pregnancy, sexual relations can cause a lot of other problems for unmarried teens.



n=4058, t=22.04, p < .0001

Pre-Post Comparisons ('89-90 Illinois Schools)

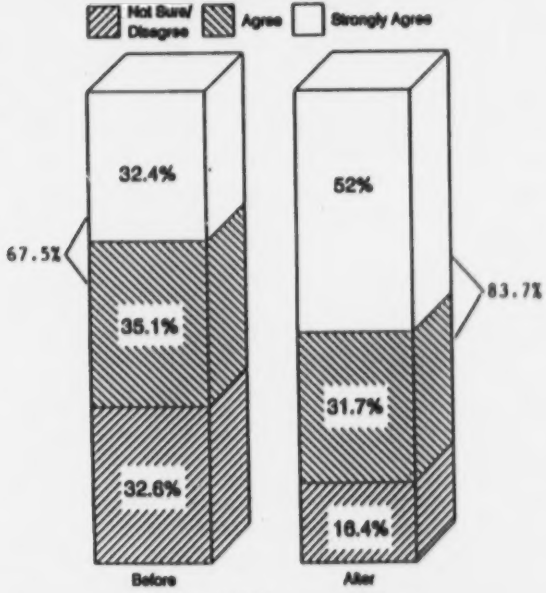
Even if there is no pregnancy, sexual relationships can cause a lot of other problems for unmarried teenagers.



Pre-Post Effect Size Comparisons by Group

Effect Size .20 = significant
.30 = large
.40 = very large

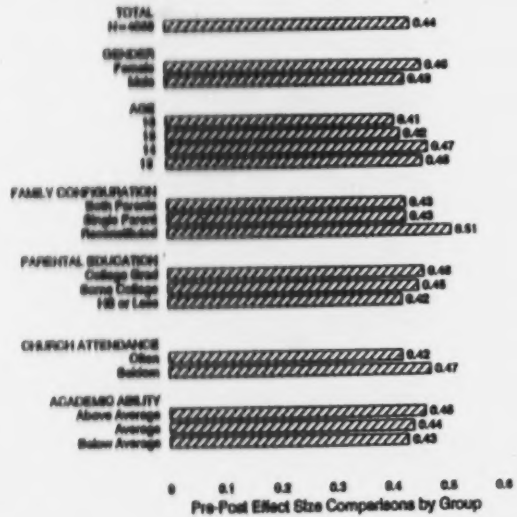
The best way for young people to avoid an unwanted pregnancy is to wait until they are married before having sex.



n=4059 t=28.2 p < .0001

Pre-Post Comparisons (Illinois Schools, 89-90)

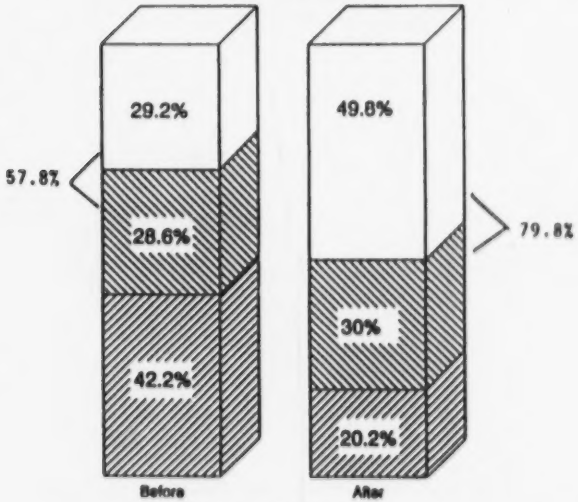
The best way for young people to avoid an unwanted pregnancy is to wait until they are married before having sex.



Pre-Post Effect Size Comparisons by Group

Effect Size .20=significant
.30=large
.40=very large

The best way for young people to keep from getting AIDS or some other sexually transmitted disease is to wait until they are married before having sex.



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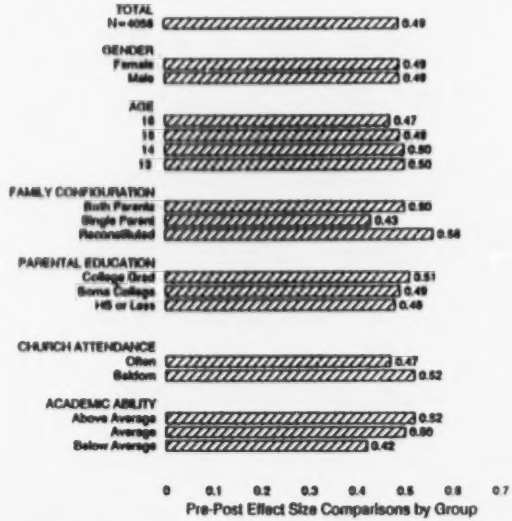

MATERIALS SUBMITTED BY KATHLEEN M. SULLIVAN—RETAINED IN COMMITTEE FILES

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Joyce Price, "Contraceptive Failure Underestimated," *The Washington Times,* July 13, 1989.

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Allan Parachini, "High AIDS Risk Leads to End of Condom Study," *The Seattle Times,* August 10, 1988.

Allan Parachini, "AIDS-Condom Study Grant Cut Off by U.S.," *Los Angeles Times,* (no date).

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"Acting-Up," *PITCH,* April 30–May 13, 1990, Issue 129.

Phillip Elmer-DeWitt, "A Bitter Pill to Swallow," *Time,* February 26, 1990.

[Article entitled: "Do Sex Education Programs Work?" from Project Respect, is retained in committee files]